

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. 66 12501 | | CERTIFICATE OF DEATH | | Registered No. 66 12501 | |
|---|-------------------------|---|--|--|--|---|--|--|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) <i>Hester E. Shaffer</i> | | 2. DATE AND HOUR OF DEATH <i>Dec 10 1966</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | M. | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | A. STATE <i>Maryland</i> | | B. COUNTY | | | |
| <i>004130 Roland Ave</i> | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | <i>13-07</i> | | | |
| | | | | D. STREET ADDRESS (If rural, give location) <i>4130 Roland Ave</i> | | | | | |
| 5. SEX <i>Female</i> | 6. RACE <i>White</i> | 7. MARRIED, NEVER MARRIED <i>Married</i> | | 8. DATE OF BIRTH <i>Feb 26 1882</i> | | 9. AGE (In years lost birth day) <i>84</i> | | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>South Dakota</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | |
| 13. FATHER'S NAME <i>Daniel W. Wilhelm</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Martha Hoshall</i> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Claud Shaffer</i> | | ADDRESS <i>4130 Roland Ave</i> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>496X 1 260X</i> | | | | CAUSE OF DEATH (A) <i>Uremia</i> DUE TO (B) <i>Arteriosclerotic Nephrosclerosis</i> DUE TO (C) <i>Advanced generalized arteriosclerosis</i> | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | <i>Diabetes Mellitus</i> | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>June 19 65</i> to <i>10 Dec 19 66</i> , that (I) (we) last saw the deceased alive on <i>10 Dec 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <i>William J. Bryson</i> | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>12 Dec 66</i> | | | |
| 23C. PHYSICIAN'S NAME (Type) <i>William J. Bryson</i> | | | | 23D. ADDRESS <i>4600 Edmondson Ave</i> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE <i>12-14-66</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Druid Ridge Cem.</i> | | 24D. LOCATION (City, town, or county) (State) <i>P. Kesville, Md</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR <i>Bryson Funeral Home</i> | | ADDRESS <i>P.O. Box 116</i> | | | |

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66 12502

BALTIMORE CITY HEALTH DEPARTMENT

66 12502

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ELEANOR

HARRISON

2. DATE AND HOUR PRONOUNCED DEAD

December 8, 1966

10:15 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

706½ W. Saratoga Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

706½ W. Saratoga Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

?

9. AGE (in years
last birthday)

52

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

?

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Hattie Dickson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Carrie Stokes 1036 Broadway

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Cirrhosis.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/8/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/13/66

23C. NAME of CEMETERY or CREMATORY

Mt Calvary Cemetery

23D. LOCATION

(City, town, or county)

(State)

A A County Md

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

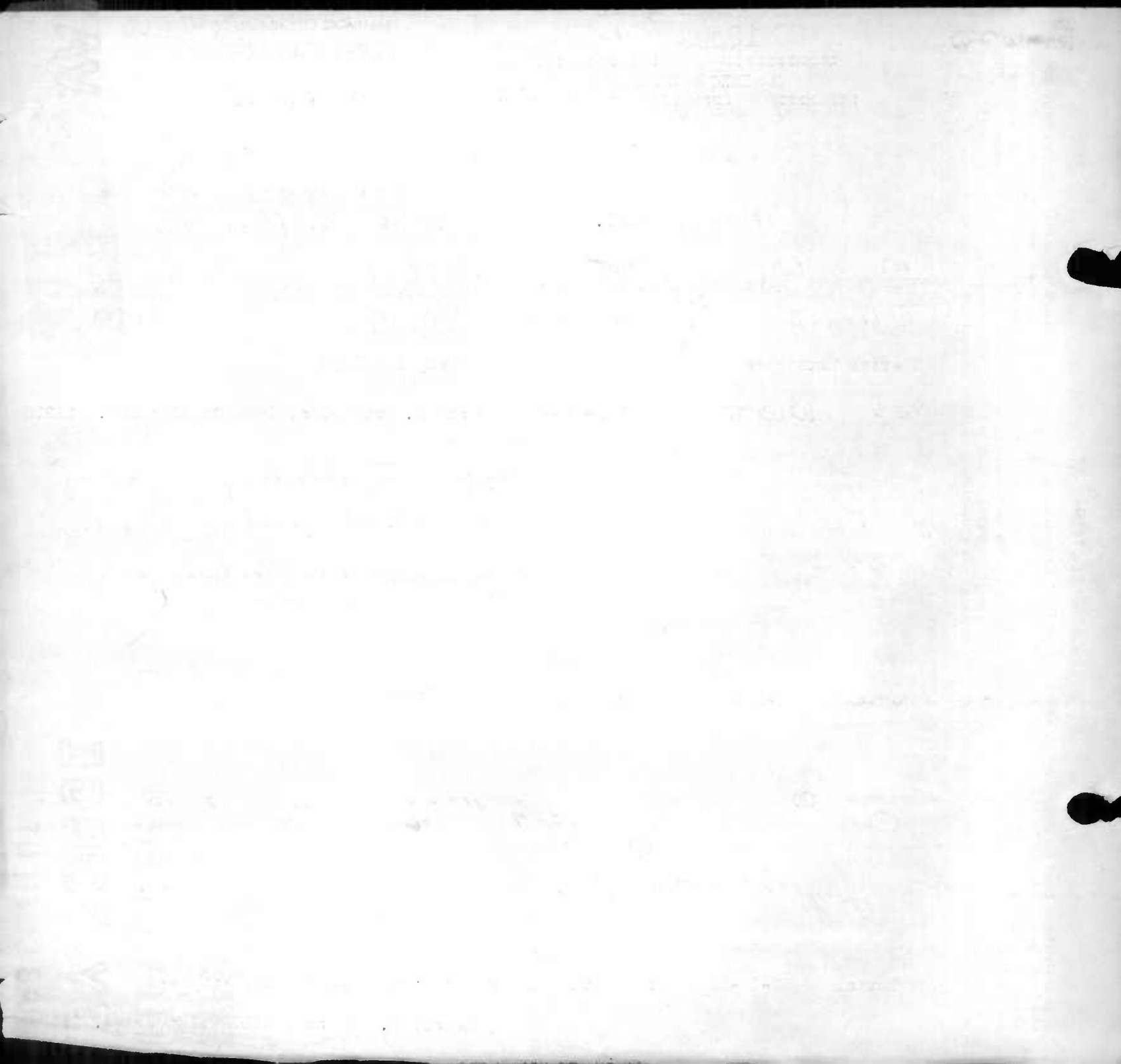
ADDRESS

Adolphus Halstead 1206 W North Av

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

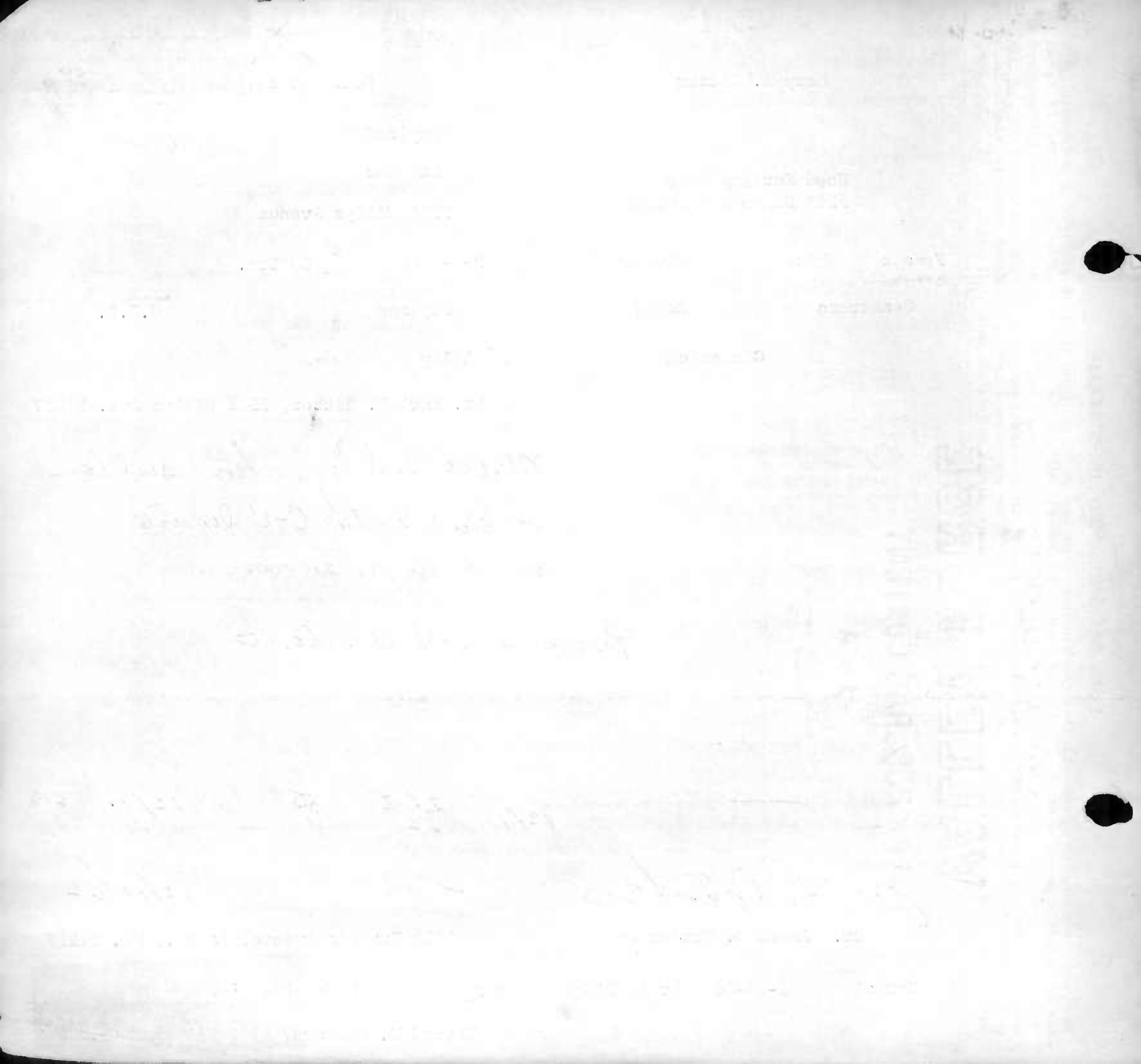
| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|--|--|--|--|---|--|
| 66 12503 | | 66 12503 | | 66 12503 | |
| CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | |
| DOMINIC CHARLES MARSIGLIA | | 12-10-66 5:35 P.M. | | FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | |
| B7 Mercy HOSP. | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | 5. SEX | |
| Maryland | | A. STATE | | m | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | B. COUNTY | | 6. RACE | |
| Baltimore 25-43 | | 2026 Griffiss Ave. | | w | |
| D. STREET ADDRESS (If rural, give location) | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | |
| 2026 Griffiss Ave. | | m | | 11-29-19 | |
| 9. AGE (In years last birthday) | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 11. BIRTHPLACE (State or foreign country) | |
| 47 | | Cleaner | | BALTO | |
| If Under 1 Yr. Months: Days: Hours: Min. | | 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | |
| USA | | Charles Marsiglia | | 14. MOTHER'S MAIDEN NAME | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| YES | | 215-12-9228 | | Mary S. Marsiglia, 2026 Griffiss Ave. 21230 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) Upper GI Bleeding | | 6 days | |
| ANTECEDENT CAUSES | | (B) cerebral hemorrhage | | 12 days | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) Hypertensive Vasculodisease | | 20 yrs | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 11-29-66 to 12-10-66, that (1) (we) last saw the deceased alive on 12-9-66 and that in my (aur) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type) | |
| Jay M. Barosh | | 12-10-66 | | M.D. | |
| 23D. ADDRESS | | 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | |
| M.D. | | Burial | | 12-13-66 | |
| 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | 24E. NAME OF REGISTRAR | |
| Baltimore National Cemetery | | Baltimore, Maryland | | Howard H. Hubbard | |
| 24F. FUNERAL DIRECTOR | | 24G. ADDRESS | | 24H. DATE REC'D BY HEALTH DEPT. | |
| Howard H. Hubbard, 4107 Wilkens Ave. 21220 | | | | DEC 12 1966 | |



FUNERAL DIRECTOR: IMPORTANT

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| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 12504</u> |
|---|--|--|--|--------------------------------|
| <div style="display: flex; justify-content: space-between;"> <div> <p>B-321</p> <p>66 12504</p> </div> <div style="text-align: center;"> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>66 12504</p> </div> </div> | | | | |
| <div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. _____</p> <p>M.E. CASE NO. _____</p> </div> <div> <p>1. NAME OF DECEASED (Type or Print) Mary A. Bitzer</p> </div> <div> <p>2. DATE AND HOUR OF DEATH December 11, 1966 <u>2:30</u> P.M.</p> </div> </div> | | | | |
| <div style="display: flex; justify-content: space-between;"> <div> <p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</p> <p>90 Hood Nursing Home 5213 Edmondson Avenue</p> </div> <div> <p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE Maryland B. COUNTY Baltimore</p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) Arbutus</p> <p>D. STREET ADDRESS (If rural, give location) 5516 Willys Avenue</p> </div> </div> | | | | |
| <div style="display: flex; justify-content: space-between;"> <div> <p>5. SEX Female</p> <p>6. RACE White</p> </div> <div> <p>7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed</p> </div> <div> <p>8. DATE OF BIRTH 3-8-1886</p> <p>9. AGE (In years last birthday) 80 Yrs.</p> </div> <div> <p>(If Under 1 Yr. Months; Days; If Under 24 Hrs. Hours; Min.)</p> </div> </div> | | | | |
| <div style="display: flex; justify-content: space-between;"> <div> <p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress</p> </div> <div> <p>10B. KIND OF BUSINESS OR INDUSTRY Retired</p> </div> <div> <p>11. BIRTHPLACE (State or foreign country) Maryland</p> </div> <div> <p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p> </div> </div> | | | | |
| <div style="display: flex; justify-content: space-between;"> <div> <p>13. FATHER'S NAME Gingerich</p> </div> <div> <p>14. MOTHER'S MAIDEN NAME Lilly</p> </div> </div> | | | | |
| <div style="display: flex; justify-content: space-between;"> <div> <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p> </div> <div> <p>16. SOCIAL SECURITY NO.</p> </div> <div> <p>17. INFORMANT ADDRESS Mr. Earl E. Bitzer, 5516 Willys Ave. 21227</p> </div> </div> | | | | |
| <p>18. CAUSE OF DEATH</p> <div style="display: flex; justify-content: space-between;"> <div> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div> <p>(A) Myocardial Infarction DUE TO</p> <p>(B) Arteriosclerosis C-V Disease DUE TO</p> <p>(C) with Hypertension</p> </div> <div> <p>INTERVAL BETWEEN ONSET AND DEATH sudden</p> </div> </div> | | | | |
| <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Previous C-V Accident.</p> | | | | |
| <p>19A. DATE OF OPERATION _____ 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ 20A. AUTOPSY? (Yes or No) _____ 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____</p> | | | | |
| <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____</p> | | | | |
| <p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) _____ 21E. INJURY OCCURRED _____ 21F. HOW DID INJURY OCCUR? _____</p> | | | | |
| <p>22. I certify that (I) (this hospital) attended the deceased from <u>2/3</u> 19<u>59</u> to <u>12/11</u> 19<u>66</u>, that (I) (we) last saw the deceased alive on <u>12/11</u> 19<u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p> | | | | |
| <p>23A. SIGNATURE <u>Dr. James N. Frederick</u> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> 23B. DATE SIGNED <u>12/12/66</u></p> | | | | |
| <p>23C. PHYSICIAN'S NAME (Type) Dr. James N. Frederick M.D. 23D. ADDRESS 1311 Francis Avenue, Balto., Md. 21227</p> | | | | |
| <p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 12-14-66 24C. NAME of CEMETERY or CREMATORY Druid Ridge Cemetery 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland</p> | | | | |
| <p>25A. DATE REC'D BY HEALTH DEPT. DEC 15 1966 25B. NAME OF REGISTRAR Robert E. Feltman 25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229</p> | | | | |



FUNERAL DIRECTOR: IMPORTANT

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| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|-------------------------|--|---|--|--|---|--|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. <u>66 12505</u> | | | | |
| BIRTH NO. <u>66 12505</u> | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Charles W. Hundtermark, Jr.</u> | | | | | 2. DATE AND HOUR OF DEATH <u>December 10, 1966</u> | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>40 St. Agnes Hospital</u> <u>Caton & Wilkens Aves.</u> | | | | | A. STATE <u>Maryland</u> B. COUNTY <u>Balto. Co</u> | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) <u>4306 Fordham Road</u> | | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>11-16-1902</u> | 9. AGE (In years lost birthday) <u>64 Yrs.</u> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dept. of Army</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Retired</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 13. FATHER'S NAME <u>Wilford Norris</u> | | | 14. MOTHER'S MAIDEN NAME <u>Clara Yingling</u> | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>None</u> | | | 16. SOCIAL SECURITY NO. <u>216-09-8424</u> | | 17. INFORMANT <u>Mrs. Clara B. Leonard, 4306 Fordham Rd.</u> | | | | |
| | | | ADDRESS <u>21229</u> | | | | | | |
| 18. <u>420.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH (A) <u>Coronary thrombosis</u> DUE TO | | INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> | | |
| | | | | | (B) <u>Myocardial infarction</u> DUE TO | | (C) <u>3 1/2 months</u> | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Sept 20 1966</u> to <u>Dec 10 1966</u> , that (I) (we) lost saw the deceased alive on <u>Dec 6 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>John F. Coolahan</u> | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>12/12/66</u> | | |
| 23C. PHYSICIAN'S NAME (Type) <u>Dr. John F. Coolahan</u> | | | 23D. ADDRESS <u>4201 Wilkens Ave., Balto., Md. 21229</u> | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12-13-66</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Meadowridge Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Howard County, Maryland</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR <u>DEC 14 1966</u> | | 25C. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u> | | | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | |
|--|--|-------------------------|------------------------------|--|--|--|--|--|--|--|--|
| BIRTH NO. 66 12506 | | | | | | CERTIFICATE OF DEATH | | | Registered No. 66 12506 | | |
| 1. NAME OF DECEASED (Type or Print) SPRINKEL, NONA B. | | | | | | 2. DATE AND HOUR OF DEATH 12-12-66 10:02A M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 ST. AGNES HOSPITAL | | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY ANNE ARUNDEL C. C. CITY OR TOWN (If outside city limits, write RURAL and give township) GLEN BURNIE 32-00 D. STREET ADDRESS (If rural, give location) 1414 GORDON DRIVE | | | | | |
| 5. SEX FEMALE | | 6. RACE WHITE | | 7. MARRIED, NEVER MARRIED WIDOWED | | 8. DATE OF BIRTH 2-17-05 | | 9. AGE (In years last birthday) 61 | | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country) VIRGINIA | | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | 13. FATHER'S NAME Andrew Schumaker | | | | | |
| 14. MOTHER'S MAIDEN NAME Mary | | | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | |
| 16. SOCIAL SECURITY NO. 217-03-9558 | | | | | | 17. INFORMANT ST. AGNES HOSPITAL ADDRESS CATON & WILKENS AVES. 29 | | | | | |
| 18. 170X I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Probable carcinomatosis from Ca of Left Breast ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Pulmonary congestion and edema of LUL pulmonary fibrosis Acute intestinal bleeding | | | | | | | | | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from DECEMBER 10 19 66 to DECEMBER 12 19 66 , that (I) (we) last saw the deceased alive on DECEMBER 12 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE John B. Herts MD | | | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-12-66 | |
| 23C. PHYSICIAN'S NAME (Type) JOHN B HERTS | | | | | | | | 23D. ADDRESS M.D. BALTO., MD. 21229 ST. AGNES HOSPITAL-CATON AND WILKENS AVE | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 24B. DATE 12-15-66 | | 24C. NAME of CEMETERY or CREMATORY Baltimore National Cemetery | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 15 1966 | | | | 25B. NAME OF REGISTRAR Howard H. Hubbard | | | | 25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | | |

125110

511024

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. <u>66 12507</u> | | | |
|--|--|----------------------|--|--|---|--|-----------------------|--|--|--|--|--|--|
| BIRTH NO. <u>66 26390</u> <u>66 12507</u> | | | | | | | | | | 66 12507 | | | |
| M.E. CASE NO. | | | | | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Baby Herring</u> | | | | | 2. DATE AND HOUR OF DEATH <u>12-10-66</u> <u>4:15 PM</u> | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <u>36 Franklin Square Hospital</u> (If not in hospital or institution, give street address or location) | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>16-02</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore City</u> D. STREET ADDRESS (If rural, give location) <u>1318 Harlem Ave</u> | | | | | | | | |
| 5. SEX <u>male</u> | | 6. RACE <u>Negro</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>never married</u> | | 8. DATE OF BIRTH <u>12-10-66</u> | | 9. AGE (In years last birthday) | | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. <u>4 minutes</u> | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life (even if retired)) <u>none</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | | 12. CITIZEN OF WHAT COUNTRY? | | | | |
| 13. FATHER'S NAME <u>Wade Herring</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Anna Bosier</u> | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> | | | | | 16. SOCIAL SECURITY NO. <u>no</u> | | 17. INFORMANT ADDRESS | | | | | | |
| 18. <u>776X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | CAUSE OF DEATH (A) <u>Immature Baby</u> DUE TO (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH <u>4 minutes</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) <u>no</u> | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (1) <u>this hospital</u> attended the deceased from <u>Dec. 10</u> 19 <u>66</u> to <u>Dec. 10</u> 19 <u>66</u> , that (1) <u>(we)</u> last saw the deceased alive on <u>Dec. 10</u> 19 <u>66</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. (1) <u>(We)</u> (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 23A. SIGNATURE <u>Kwang Hi Shin</u> M.D. | | | | | | | | | | 23B. DATE SIGNED <u>12-10-66</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>Kwang Hi SHIN</u> M.D. | | | | | 23D. ADDRESS <u>Franklin Square Hospital</u> | | | | | | | | |
| 24A. BURIAL CREMATION REMOVAL (Specify) | | | 24B. DATE | | | 24C. NAME of CEMETERY or CREMATORY <u>FR. SQ. HOSPITAL</u> | | | 24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u> | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 15 1966</u> | | | | 25B. NAME OF REGISTRAR <u>P. J. E. Talma</u> | | | | 25C. FUNERAL DIRECTOR ADDRESS <u>HOSPITAL DISPOSAL</u> | | | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

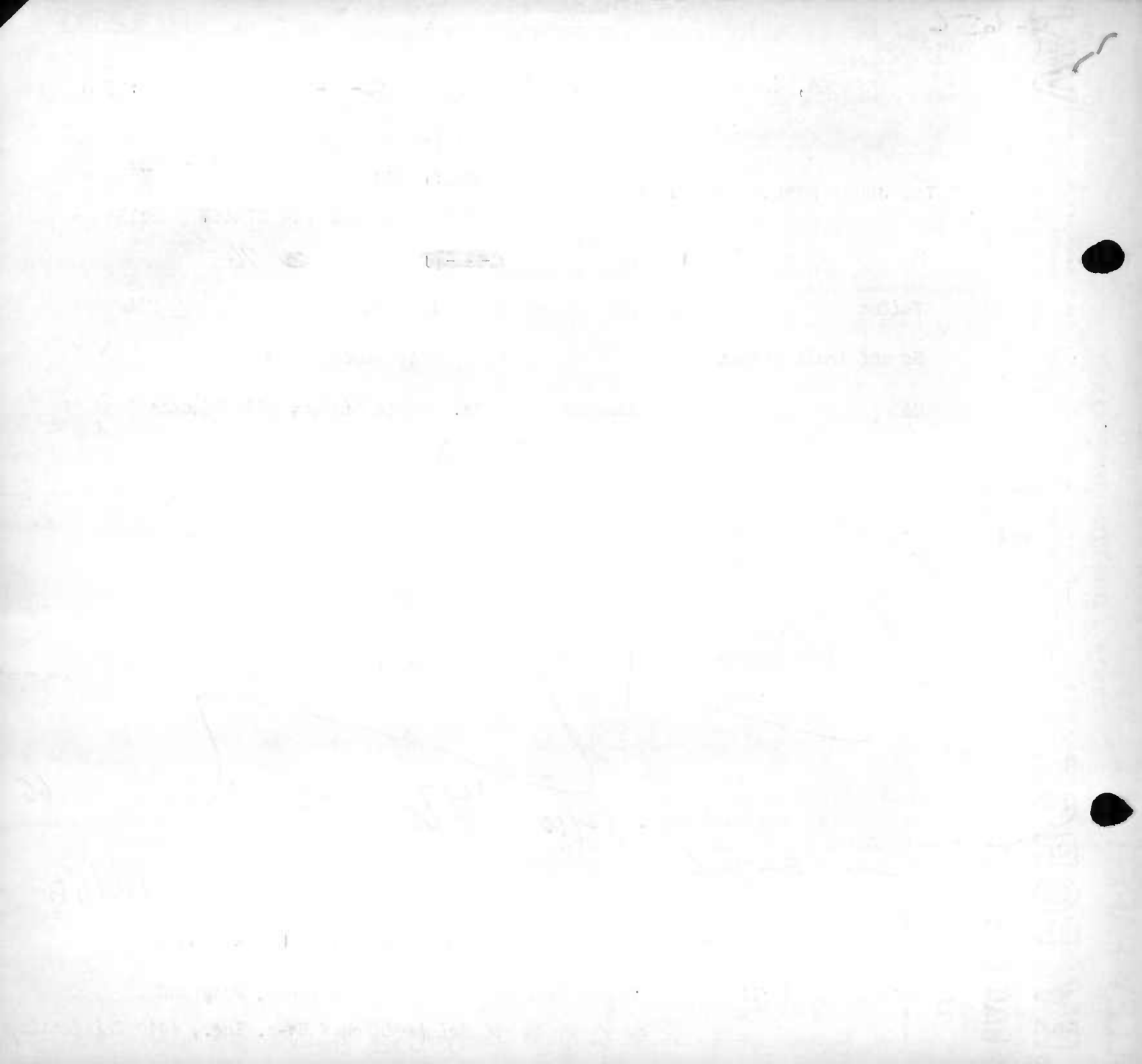
| BIRTH NO. 66 12508 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12508 | |
|---|---------------------|---|---------------------------------------|---|--|--|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) ETTA H. KEISER | | 2. DATE AND HOUR OF DEATH 12/10/66 11.55 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 47 SINAI HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-00 D. STREET ADDRESS (If rural, give location) 11 Slade Ave #8 | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W | 8. DATE OF BIRTH 11/10/1900 | 9. AGE (In years last birthday) 72 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY At Home | | 11. BIRTHPLACE (State or foreign country) BALTIMORE, Md. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A | |
| 13. FATHER'S NAME Adolph B. Hirschmann | | | | 14. MOTHER'S MAIDEN NAME Jennie Potts | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 218-36-6178 | | 17. INFORMANT DAUGHTER MILORED SHULBANK ADDRESS 2110 CARTERDALE RD | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 422.14-260X | | | | CAUSE OF DEATH (A) DUE TO C. V. A (B) DUE TO A. S. C. V. D (C) DUE TO ANEMIA | | INTERVAL BETWEEN ONSET AND DEATH 25 DAYS YEARS YEARS | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II | | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus | | years | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/1/66 to 12/10/1966 , that (I) (we) lost saw the deceased alive on 12/10 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Eduardo Hidalgo M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/10/66 | |
| 23C. PHYSICIAN'S NAME (Type) EDUARDO HIDALGO M.D. | | | | 23D. ADDRESS Sinai Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/12/66 | | 24C. NAME of CEMETERY or CREMATORY Chizuk Amuno | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR DEC 15 1966 | | 25C. FUNERAL DIRECTOR ADDRESS Sol Levinson & Bros. Inc., 6010 Reisterstown | | | |

25 10/10/10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

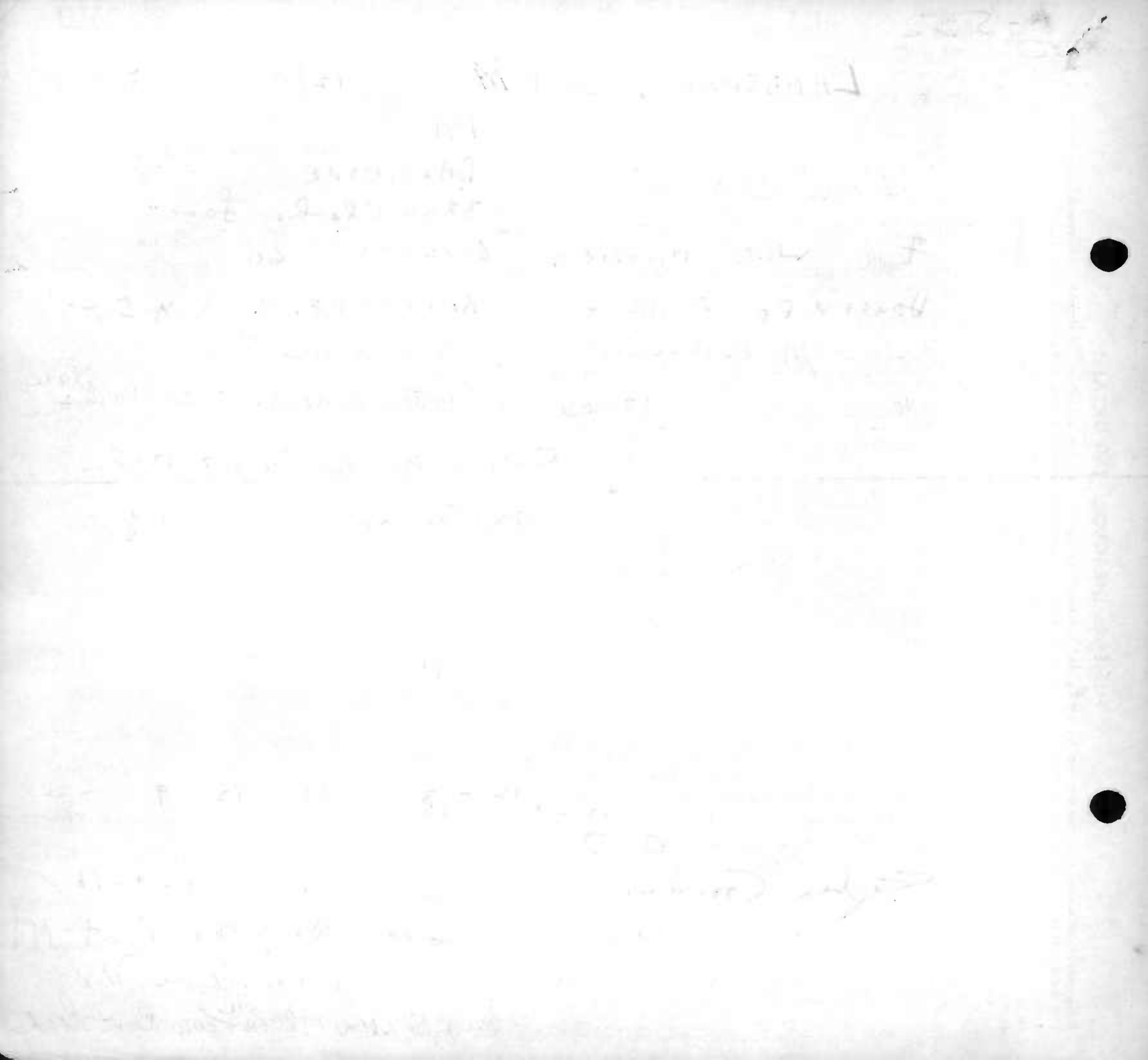
| | | | | | |
|---|---------------------|---|---------------------------------------|--|---|
| BIRTH NO. 66 12509 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12509 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) KRAMER, CHARLES | | 2. DATE AND HOUR OF DEATH 12-10-66 7:15AM M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 THE JOHNS HOPKINS HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 6-04 D. STREET ADDRESS (If rural, give location) 228 NORTH CHESTER STREET 21231 | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWER | 8. DATE OF BIRTH [REDACTED] | 9. AGE (in years lost birthday) 76 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor | | 10B. KIND OF BUSINESS OR INDUSTRY Clothing | | 11. BIRTHPLACE (State or foreign country) Lithuania | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Samuel Louis Kramer | | 14. MOTHER'S MAIDEN NAME Mary Block | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT ADDRESS Mrs. Samuel Minkov 3717 Pinelea Road #8 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) CVA. | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/7 1966 to 12/10 1966 , that (I) (we) last saw the deceased alive on 12/10 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE [Signature] | | | | 23B. DATE SIGNED 12/10/66 | |
| 23C. PHYSICIAN'S NAME (Type) W Stan Wilson | | | | 23D. ADDRESS THE JOHNS HOPKINS HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/11/66 | | 24C. NAME OF CEMETERY or CREMATORY Workman Circle | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. 1966 | | | |
| 25B. NAME OF REGISTRAR [Signature] | | 25C. FUNERAL DIRECTOR ADDRESS Sol Levinson & Bros. Inc., 6010 Reisterstown | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

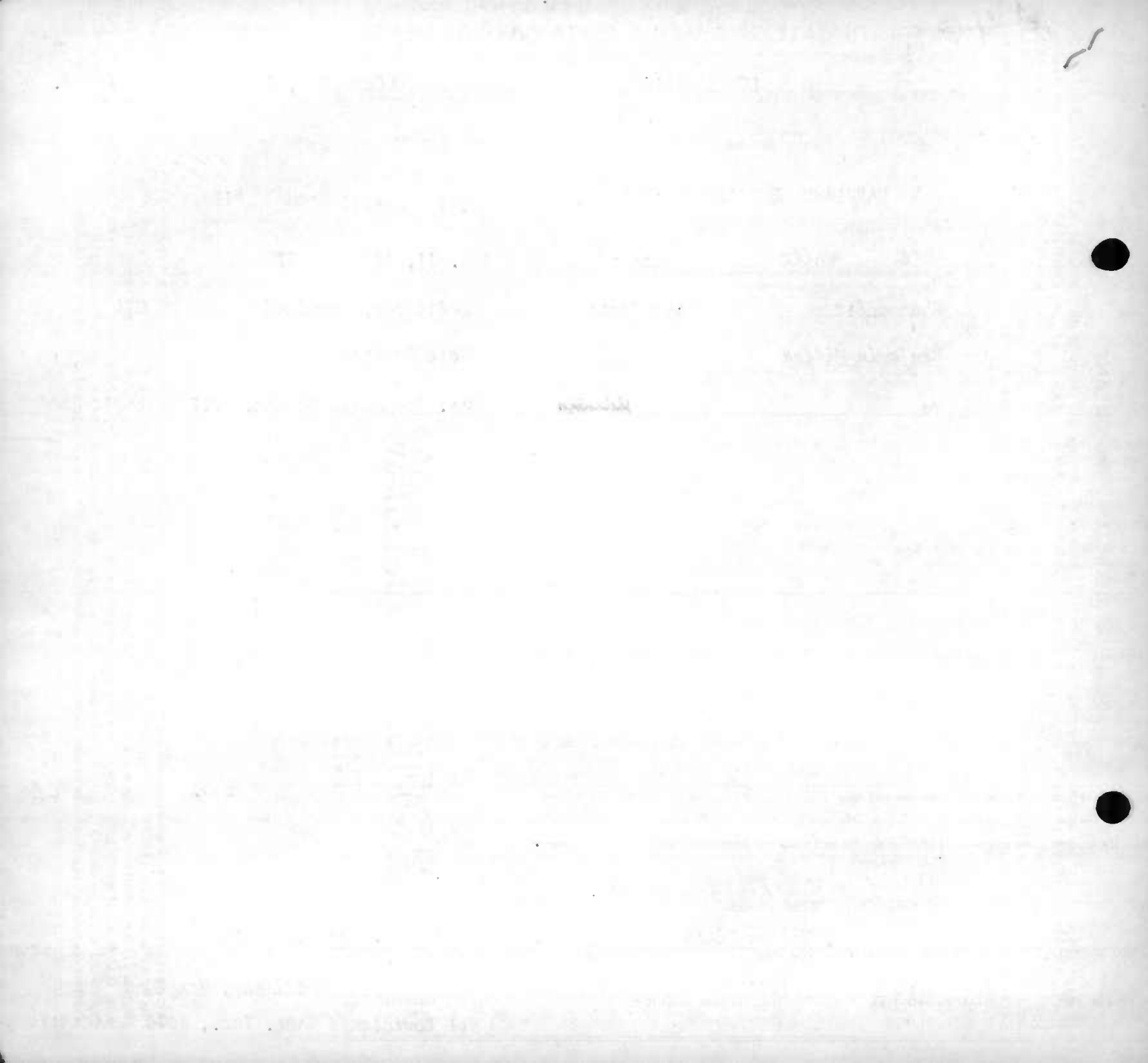
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12510 | |
|---|------------------|--|-----------------------------|--|--|
| CERTIFICATE OF DEATH | | | | | |
| M.E. CASE NO. 332 | | 66 12510 | | | |
| 1. NAME OF DECEASED (Type or Print) LANDSMAN, SOPHIA | | 2. DATE AND HOUR OF DEATH 12/9/66 3:30 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinai Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 27-20 | | | |
| (If not in hospital or institution, give street address or location) | | D. STREET ADDRESS (If rural, give location) 3800 Clarke Lane | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 6-10-06 | 9. AGE (In years last birthday) 60 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY at Home | | 11. BIRTHPLACE (State or foreign country) BALTIMORE, MD. | |
| 13. FATHER'S NAME Louis M. Bresler | | 14. MOTHER'S MAIDEN NAME Late Sarah? | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT H. Martin Landsman - 3800 Clarke Lane | |
| 18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cerebral Vascular Accident | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH 12 hrs. | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) Hypertension | | 1 year | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-8-66 to 12-9-66, that (I) (we) last saw the deceased alive on 12-9-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Stephen Gordon M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED 12-9-66 | |
| 23C. PHYSICIAN'S NAME (Type) Stephen Gordon | | 23D. ADDRESS Sinai Hospital Balt Md | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Dec 11/66 | | 24C. NAME OF CEMETERY or CREMATORY Beth El | |
| 24D. LOCATION (City, town, or county) (State) Randallstown, Md. | | 25A. DATE REC'D BY HEALTH DEPT. DEC 15 1966 | | | |
| 25B. NAME OF REGISTRAR J. J. E. 3300 | | 25C. FUNERAL DIRECTOR 2nd Joe Larson 9 Pros 6010 Rest Road | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12511 | |
|---|-------------------------|--|--|--|---|
| BIRTH NO. 66 12511 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) LEWIS MILLER | |
| 2. DATE AND HOUR OF DEATH DECEMBER 9, 1966 11:00 A. M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 MARYLAND GENERAL HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-20 D. STREET ADDRESS (If rural, give location) 3707 Bancroft Road #15 | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH Feb. 11, 1909 | 9. AGE (In years lost birthday) 57 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pharmacist | | 10B. KIND OF BUSINESS OR INDUSTRY Drug Store | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 13. FATHER'S NAME Benjamin Miller | | 14. MOTHER'S MAIDEN NAME Rose Goldser | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 218-32-2421 | | 17. INFORMANT Mrs. Jeannette Miller, 3707 Bancroft Road | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) acute coronary thrombosis | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 5 minutes | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1934 19 1966 to 12/9 19 66 . that (I) (we) last saw the deceased alive on 12/8/66 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Dr. Milton Kirsh | | 23B. DATE SIGNED 12/10/66 | | 23C. PHYSICIAN'S NAME (Type) Dr. Milton Kirsh | |
| 23D. ADDRESS 4000 W. Northern Parkway | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/11/66 | | 24C. NAME of CEMETERY or CREMATORY Beth Tfiloh | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 15 1966 | | 25B. NAME OF REGISTRAR Dr. E. J. ... | | 25C. FUNERAL DIRECTOR Sol Levinson & Bros. Inc., 6010 Reisterstown | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12512 | |
|--|---------------------|---|---|--|---|
| BIRTH AND DEATH CERTIFICATE OF DEATH | | | | | |
| M.E. CASE NO. 635 | | | 66 12512 | | |
| 1. NAME OF DECEASED (Type or Print) FRIEDMAN, SAMUEL S. | | | 2. DATE AND HOUR OF DEATH 12/10/66 1540 AM | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinai Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALT C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALT D. STREET ADDRESS (If rural, give location) 3602 GLENGYLE AVE | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 4/15/96 | 9. AGE (In years lost birthday) 70 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY Real Estate | 11. BIRTHPLACE (State or foreign country) Russia | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Benjamin Friedman | | | 14. MOTHER'S MAIDEN NAME Lena ? | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 215-10-9101 | 17. INFORMANT Mrs. Lena Friedman, 3602 Glengyle Avenue | | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) MYOCARDIAL INFARCTION DUE TO (B) ASHD DUE TO (C) 20 yrs | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 11/17/66 19 to 12/10/66 19, that (I) (we) last saw the deceased alive on 12/10/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE David A. Spott | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/10/60 |
| 23C. PHYSICIAN'S NAME (Type) D. A. SPOTT | | | 23D. ADDRESS SINAI HOSPITAL | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/11/66 | | 24C. NAME of CEMETERY or CREMATORY Shaarei Zion | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. DEC 10 1966 | | | |
| 25B. NAME OF REGISTRAR Sol. Lanson & Bros. Inc. | | 25C. FUNERAL DIRECTOR ADDRESS 6010 Reisterstown | | | |

66 12513

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 12513

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

IRMA (KLAFF) DAVISON

2. DATE AND HOUR PRONOUNCED DEAD

December 10, 1966 6:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 3211 Bancroft Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3211 Bancroft Road

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

August 24, 1913

9. AGE (In years
last birthday)

53

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Harry Klaff

14. MOTHER'S MAIDEN NAME

Sarah Schreiber

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

Unknown

17. INFORMANT

ADDRESS

Mr. Ivin Davison, 3211 Bancroft Road

| CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
|--|--|-------------------------------------|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) (A) <u>Overdose of Barbiturates</u> DUE TO | | |
| II ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) _____ DUE TO (C) _____ | | |
| III OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

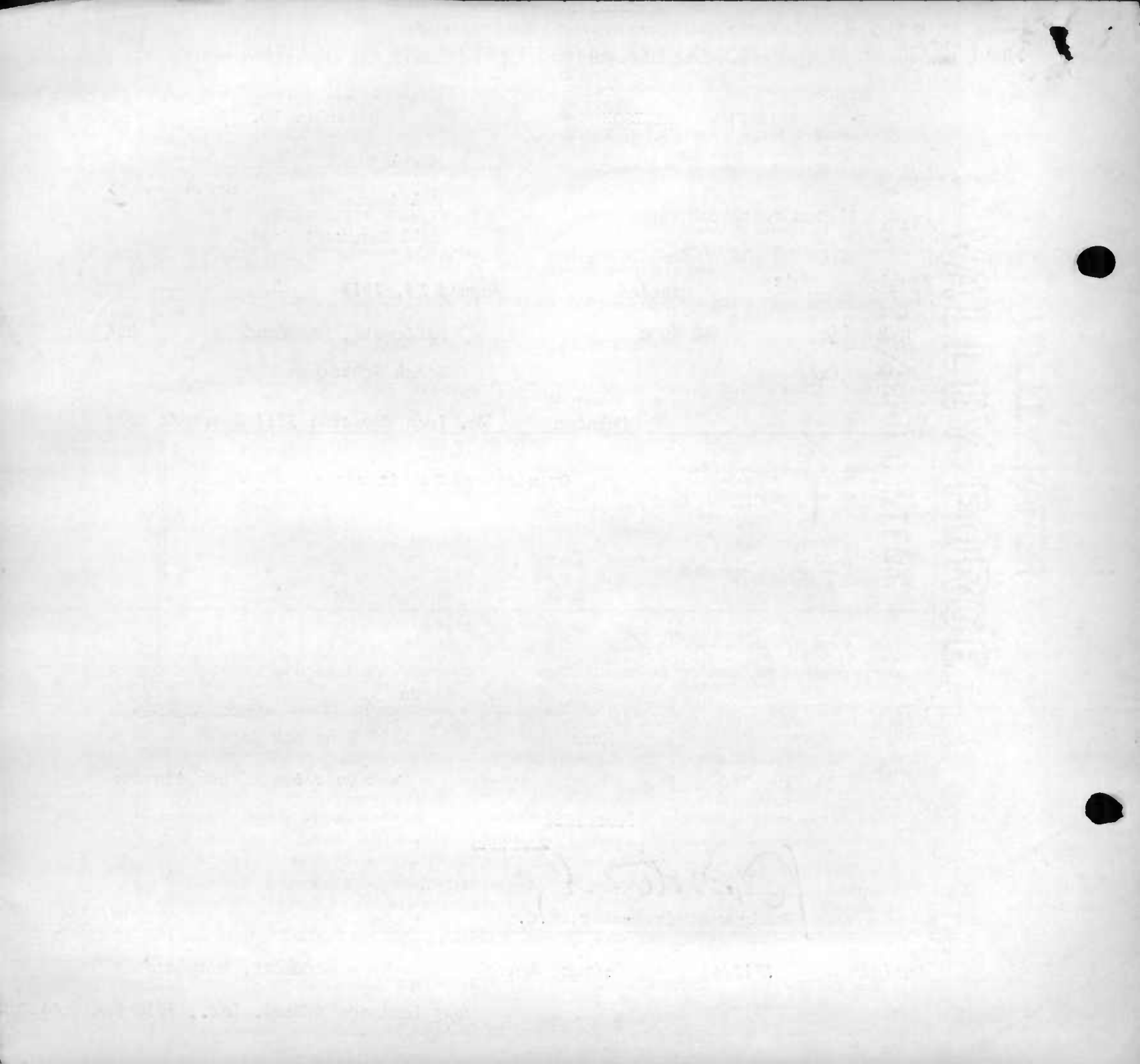
MEDICAL CERTIFICATION

| | | | |
|--|--|---|---|
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| | | No | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIB- UTING CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | |
| | Home | 3211 Bancroft Road | |
| 21D. TIME OF INJURY (APPROX.) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) 12 10 '66 P. | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | Took Overdose of Barbiturates | |

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Rudiger Breiteneker M.D. CHIEF MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) Rudiger Breiteneker, M.D. ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐ DATE SIGNED 12/11/66

| | | | |
|---|------------------------|------------------------------------|---|
| 23A. BURIAL CREMATION, REMOVAL (Specify) | 23B. DATE | 23C. NAME of CEMETERY or CREMATORY | 23D. LOCATION (City, town, or county) (State) |
| Burial | 12/12/66 | Chizuk Amuno | Baltimore, Maryland |
| 24A. DATE REC'D BY HEALTH DEPT. | 24B. NAME OF REGISTRAR | 24C. FUNERAL DIRECTOR | ADDRESS |
| DEC 12 1966 | Lab E. Taylor | Sol Levinson & Bros. Inc. | 6010 Reisterstown |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12514 | |
|--|--|--|--|-------------------------|--|
| <div style="display: flex; justify-content: space-between;"> 37 66 12514 </div> <div style="display: flex; justify-content: space-between;"> 32 CERTIFICATE OF DEATH </div> | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div> M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) </div> <div> 2. DATE AND HOUR OF DEATH </div> </div> | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div> 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) </div> <div> 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE B. COUNTY </div> </div> | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div> 5. SEX Male </div> <div> 6. RACE White </div> <div> 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married </div> <div> 8. DATE OF BIRTH 9/12/1912 </div> <div> 9. AGE (In years last birthday) 54 </div> <div> 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland </div> <div> 12. CITIZEN OF WHAT COUNTRY? USA </div> </div> | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div> 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocery </div> <div> 10B. KIND OF BUSINESS OR INDUSTRY Wholesale </div> <div> 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland </div> <div> 12. CITIZEN OF WHAT COUNTRY? USA </div> </div> | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div> 13. FATHER'S NAME Morris Goldscheider </div> <div> 14. MOTHER'S MAIDEN NAME Sarah Weinstein </div> </div> | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div> 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No </div> <div> 16. SOCIAL SECURITY NO. Unknown </div> <div> 17. INFORMANT Mrs. Minnie Goldscheider, 7007 Park Heights Avenue </div> </div> | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div> 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div> CAUSE OF DEATH (A) DUE TO Coronary Occlusion anterior division of (B) DUE TO Coronary arteries (C) </div> <div> INTERVAL BETWEEN ONSET AND DEATH 1 yr. </div> </div> | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div> 19A. DATE OF OPERATION 1966-11-11 </div> <div> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED </div> <div> 20A. AUTOPSY? (Yes or No) </div> <div> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? </div> </div> | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div> 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) </div> <div> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) </div> <div> 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) </div> </div> | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div> 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) </div> <div> 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> </div> <div> 21F. HOW DID INJURY OCCUR? </div> </div> | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div> 22. I certify that (I) (this hospital) attended the deceased from 4-7-66 to 12-9-66, that (I) (we) last saw the deceased alive on 8-5-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. </div> </div> | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div> 23A. SIGNATURE Irving Sauber </div> <div> 23B. DATE SIGNED 12-9-66 </div> </div> | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div> 23C. PHYSICIAN'S NAME (Type) Irving Sauber </div> <div> 23D. ADDRESS 6905 Park Heights Avenue </div> </div> | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div> 24A. BURIAL CREMATION, REMOVAL (Specify) Burial </div> <div> 24B. DATE 12/11/66 </div> <div> 24C. NAME OF CEMETERY or CREMATORY Beth Tfiloh </div> <div> 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland </div> </div> | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div> 25A. DATE REC'D BY HEALTH DEPT. DEC 15 1966 </div> <div> 25B. NAME OF REGISTRAR Sol Levinson & Bros. Inc. </div> <div> 25C. FUNERAL DIRECTOR ADDRESS 6010 Reisterstown </div> </div> | | | | | |

FROM

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | 66 12515 | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 66 12515 | |
|---|---------------------|---|--|---|--|--|--|-----------------------------|--|
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Helen Desser</i> | | | | 2. DATE AND HOUR OF DEATH <i>12/10/66</i> <i>8</i> <i>P.M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>Balt. Co.</i> | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i> <i>53-00</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>42 Sinai Hospital</i> | | D. STREET ADDRESS (If rural, give location) <i>2413 HAL CIRCLE #9</i> | | | | | | | |
| 5. SEX <i>F</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>W</i> | | 8. DATE OF BIRTH <i>76</i> | 9. AGE (In years lost birthday) <i>76</i> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HW</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>HOME</i> | | 11. BIRTHPLACE (State or foreign country) <i>RUSSIA</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | |
| 13. FATHER'S NAME <i>UNKNOWN</i> | | | | 14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i> <i>6811 Gist Ave #15</i> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i> | | 16. SOCIAL SECURITY NO. <i>—</i> | | 17. INFORMANT <i>DAUGHTER SONIA COHEN</i> ADDRESS <i>6811 Gist Ave #15</i> | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>422.11-260X</i> | | CAUSE OF DEATH (A) DUE TO <i>C.V.A.</i> (B) DUE TO <i>A.S.C.U.D.</i> (C) <i>—</i> | | | | INTERVAL BETWEEN ONSET AND DEATH <i>2 DAYS</i> <i>years</i> | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>II</i> | | <i>Diabetes Mellitus</i> | | | | <i>years</i> | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>— NO</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>12/8/1966</i> to <i>12/10/1966</i> , that (I) <i>(we)</i> lost saw the deceased alive on <i>12/10/1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <i>(We)</i> (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <i>Eduardo Hidalgo</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED <i>12/10/66</i> | | | | | |
| 23C. PHYSICIAN'S NAME (Type) <i>EDUARDO HIDALGO</i> M.D. | | | | 23D. ADDRESS <i>Sinai Hospital, Balt, Md.</i> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 24B. DATE <i>12/11/66</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Mishkin Israel Cong.</i> | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 15 1966</i> | | 25B. NAME OF REGISTRAR <i>25B. E. E. E. E.</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>SOL LEVINSON & BROS INC. 6010 Reist Rd.</i> | | | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | | |
|---|--|----------------------|--|---|----------------------|--|--|---|----------------------------------|--|--|--|--|--|----------------------------------|--|
| BIRTH NO. 66 12516 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 66 12516 | | | | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Mary DREXLER</i> | | | | | | | | | | 2. DATE AND/HOUR OF DEATH <i>12/12/66 10⁰⁰ P M.</i> | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>44 Union Memorial Hosp. Balt. Md.</i> | | | | | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>53-00 22 Leslie Avenue</i> | | | | | | |
| 5. SEX <i>F</i> | | 6. RACE <i>CAUCA</i> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>(m)</i> | | 8. DATE OF BIRTH <i>4/8/14</i> | | 9. AGE (In years last birthday) <i>52</i> | | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i> | | 11. BIRTHPLACE (State or foreign country) <i>Md.</i> | | | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i> | | | | | | |
| 13. FATHER'S NAME <i>Mathias Drexler</i> | | | | | | 14. MOTHER'S MAIDEN NAME <i>Caroline Dunninger</i> | | | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i> | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <i>Mr Frank Drexler 22 Leslie Avenue 21236</i> | | | | | | | | | | |
| 18. <i>578X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | CAUSE OF DEATH (A) <i>U.S. Bleeding</i> DUE TO (B) DUE TO (C) DUE TO | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION <i>12/5</i> | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>GI bleeding</i> | | | | 20A. AUTOPSY? (Yes or No) <i>no</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | | | | | | |
| 22. I certify that (I) <i>(the hospital)</i> attended the deceased from <i>11/30</i> 19 <i>66</i> to <i>12/12</i> 19 <i>66</i> , that <i>(I/we)</i> last saw the deceased alive on <i>12/12</i> 19 <i>66</i> and that in <i>(my/our)</i> opinion death occurred on the date and hour and from the causes stated above. <i>(We)</i> <i>(did)</i> <i>(did not)</i> view the body after death. | | | | | | | | | | | | | | | | |
| 23A. SIGNATURE <i>Robert P. Doyle</i> | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED <i>12/12/66</i> | | | | | | | |
| 23C. PHYSICIAN'S NAME (Type) <i>ROBERT P. DOYLE</i> | | | | | | 23D. ADDRESS <i>THE UNION MEMORIAL HOSPITAL Union Memorial Hospital</i> | | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | | | 24B. DATE <i>12-16-1966</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Holy Redeemer Cemetery</i> | | | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i> | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 17 1966</i> | | | | 25B. NAME OF REGISTRAR <i>R. B. E. Doyle</i> | | | | 25C. FUNERAL DIRECTOR ADDRESS <i>Lazarus Funeral Home 7401 Belair Road (36)</i> | | | | | | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|-------------------------|---|--|---|----------------------------|--|-----------------------------|
| BIRTH NO. 66 12517 | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 66 12517 | |
| 1. NAME OF DECEASED (Type or Print) <u>Johnson, Florence Howard</u> | | | | 2. DATE AND HOUR OF DEATH <u>12/12/1966</u> <u>9:00</u> P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>42 Sinai Hospital of Baltimore Inc</u> | | | | A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore Co.</u> | | | |
| (If not in hospital or institution, give street address or location) | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | | |
| | | | | D. STREET ADDRESS (If rural, give location) <u>59 Featherbed Lane Owings Mills</u> | | | |
| 5. SEX <u>Fe.</u> | 6. RACE <u>Negro</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married wid.</u> | 8. DATE OF BIRTH <u>5/15/1890</u> | 9. AGE (In years last birthday) <u>76</u> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Howard</u> | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT <u>Wm B. Johnson</u> ADDRESS <u>104 W. University Pkwy. Balto. 10, Md.</u> | | | |
| 18. <u>420.01</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) <u>Chronic Congestive heart failure - months</u> DUE TO (B) <u>Arteriosclerotic heart disease - years</u> DUE TO (C) <u>—</u> | | | |
| INTERVAL BETWEEN ONSET AND DEATH <u>—</u> | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>massive diabetic ulcers of buttocks - 2 weeks</u> | | | | | | | |
| 19A. DATE OF OPERATION <u>—</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u> | | 20A. AUTOPSY? (Yes or No) <u>—</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>—</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u> | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>—</u> | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? <u>—</u> | | | |
| 22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>10/19/66</u> to <u>12/12/66</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>12/12/66</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Erwin H. Hesselberg</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED <u>12/12/66</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>Erwin H. Hesselberg</u> | | | | 23D. ADDRESS <u>Sinai Hospital</u> | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12/15/66</u> | | 24C. NAME of CEMETERY or CREMATORY <u>St. Lukes Meth. Cem.</u> | | 24D. LOCATION (City, town, or county) (State) <u>Reisterstown, Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>—</u> | | 25B. NAME OF REGISTRAR <u>—</u> | | 25C. FUNERAL DIRECTOR <u>W. J. Eckhardt</u> ADDRESS <u>Owings Mills, Md.</u> | | | |

Distance

Camps to

76

11.2 H

Unknown

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to Mr. B. Johnson
1000

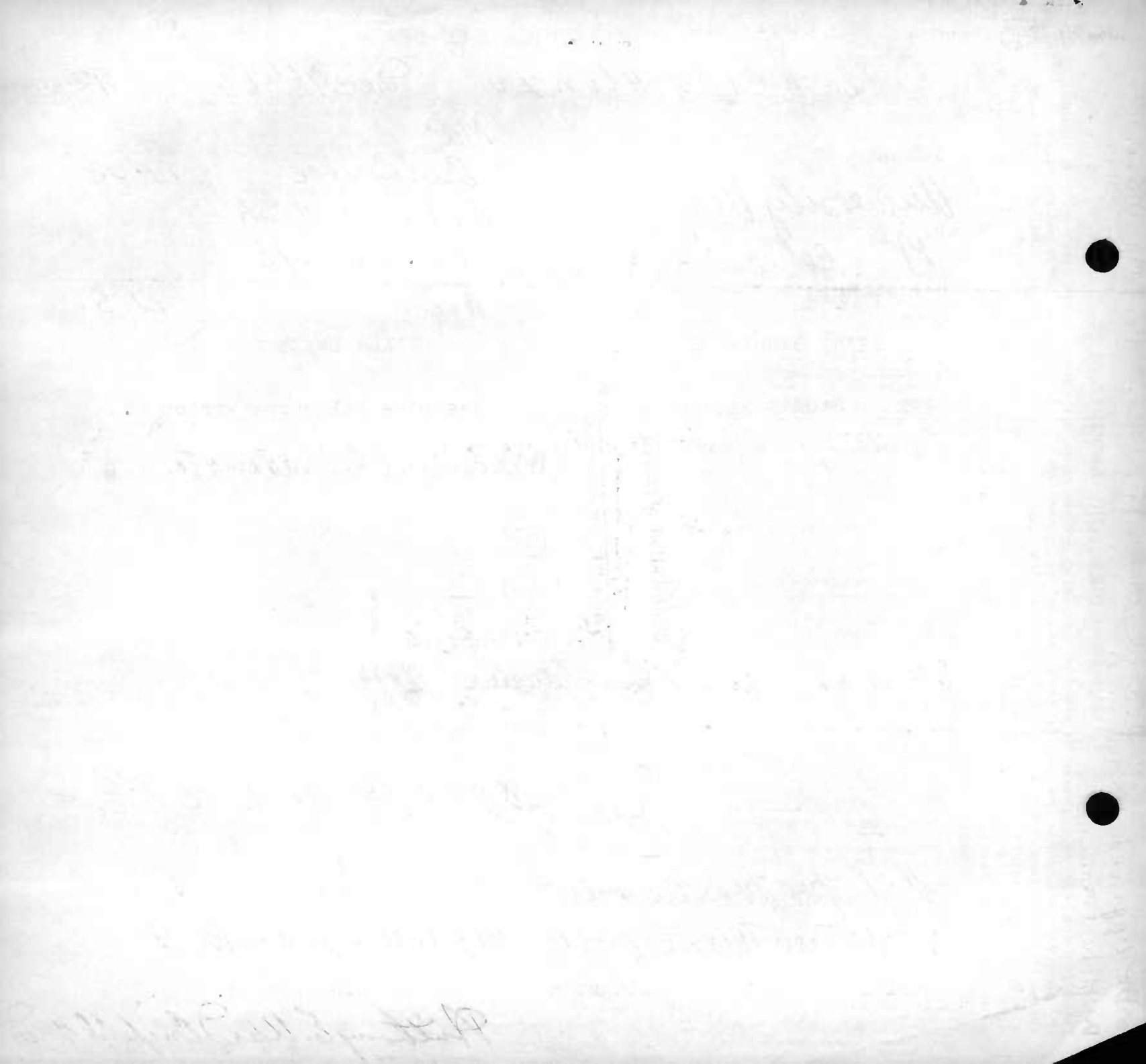
No

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Released on Approval - Per. Mr. Mason
By MCO
Medical Examiner
Approved
Funeral Director: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

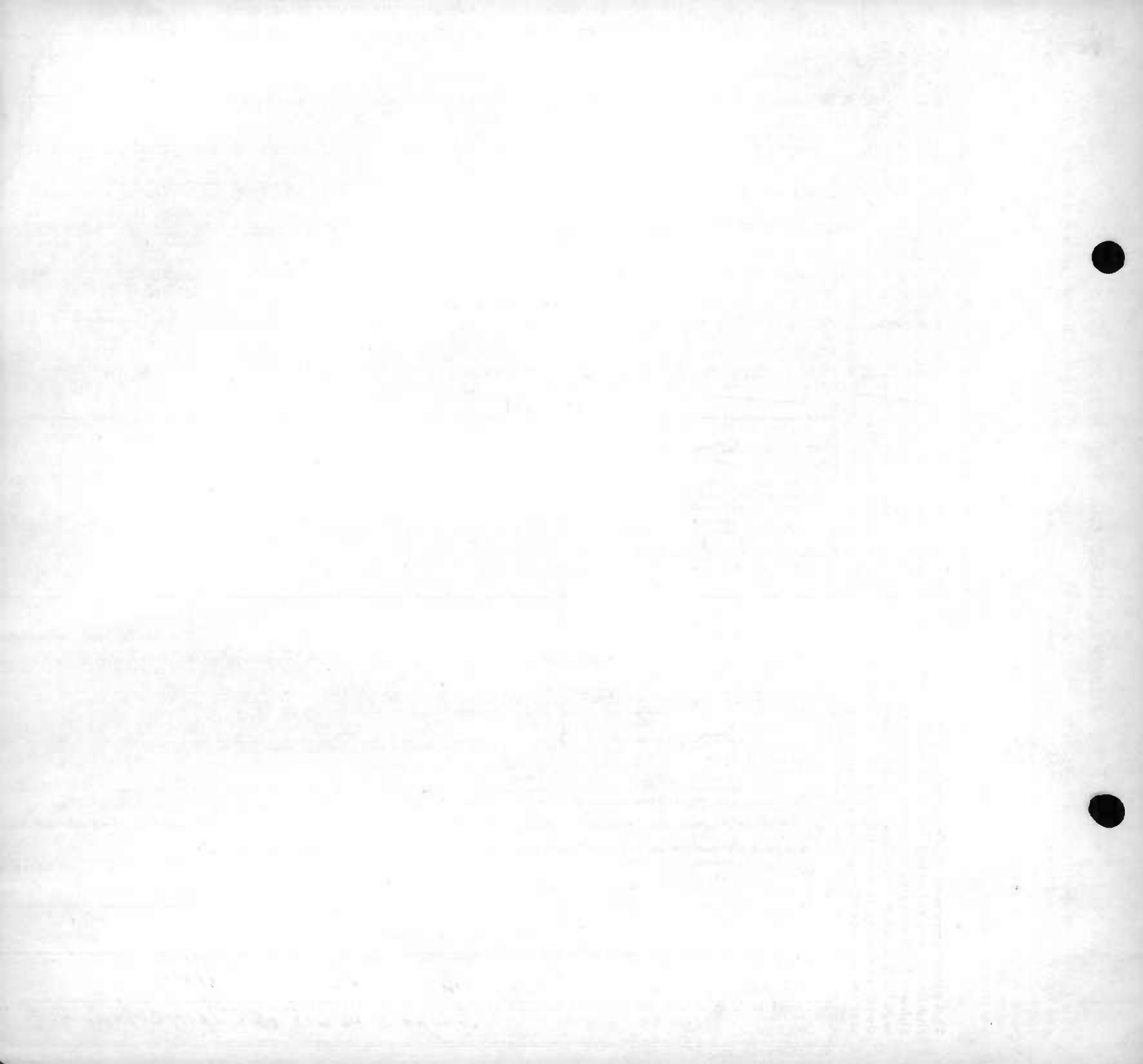
| | | | | | |
|---|--|--|--|---|--|
| BIRTH NO. 66 12518 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12518 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Dashields Alonzo</i> | | 2. DATE AND HOUR OF DEATH <i>Dec 9th 66</i> | | <i>9:00 p.m.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>University Hospital</i> | | A. STATE <i>Md.</i> | | B. COUNTY | |
| 5. SEX <i>M</i> | | 6. RACE <i>col.</i> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>SINGLE</i> | |
| 8. DATE OF BIRTH <i>8 Feb. 1918</i> | | 9. AGE (In years last birthday) <i>48</i> | | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>CARPENTER</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>N.C.</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i> | | 13. FATHER'S NAME <i>PERRY DASHIELDS</i> | | 14. MOTHER'S MAIDEN NAME <i>ANNA HANDY</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>YES 8Aug45 21Dec45</i> | | 16. SOCIAL SECURITY NO. <i>M.</i> | | 17. INFORMANT <i>Beatrice Milbourne Marion Md</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease or injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, give rise to the above cause (A) stating UNDERLYING CONDITION last.) | | Subdural hematoma | | ? | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Pneumonia</i> | | | | | |
| 19A. DATE OF OPERATION <i>10/31/66</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Subdural hematoma</i> | | 20A. AUTOPSY? (Yes or No) <i>Yes</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>?</i> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>00-00</i> | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Oct 27th 1966</i> to <i>Dec 9th 1966</i> and that (I) (we) last saw the deceased alive on <i>Dec 9th 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE <i>Wigl. Thor Thorsteinsson</i> | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) <i>Wigl. Thor Thorsteinsson</i> | | 23D. ADDRESS <i>903 Nottingham Rd 1B</i> | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12/15/66</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Kingston</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Kingston Md.</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 15 1966</i> | | 25B. NAME OF REGISTRAR <i>Anthony E. Ward</i> | |
| 25C. FUNERAL DIRECTOR <i>Ward</i> | | 25D. ADDRESS <i>Ward</i> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12519 | |
|---|---------------------|--|---|--|--|
| BIRTH NO. 66 12519 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) STEINHORN, Julius | | 2. DATE AND HOUR OF DEATH 12-12-1966 11:50 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 91 LEVINDALE | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 27-17 Levindale Hebrew Home & Infirmary Belvedere at Green Spring | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W | 8. DATE OF BIRTH 7-17-83 | 9. AGE (In years last birthday) 83 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chiropract | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) AUSTRIA | |
| 13. FATHER'S NAME Morris Steinhorn | | | 14. MOTHER'S MAIDEN NAME Toby | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 216-32-4581 | | 17. INFORMANT ADDRESS Sidney Steinhorn, Son 4205 Liberty Hgts | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 5-27-11 Bronchopneumonia (A) DUE TO Chronic Emphysema (B) DUE TO (C) _____ | | | INTERVAL BETWEEN ONSET AND DEATH 10 days Years | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 11-2-1962 to 12-12-1966 , that (I) (we) last saw the deceased alive on 12-12-1962 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Jose Ardaiz | | | 23B. DATE SIGNED 12-12-66 | | |
| 23C. PHYSICIAN'S NAME (Type) Jose ARDAIZ | | | 23D. ADDRESS M.O. 5912 Cross Country Blvd. BALTIMORE, Md. 21215 | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/15/66 | | 24C. NAME OF CEMETERY or CREMATORY HEBREW FRIENDSHIP | |
| 24D. LOCATION BALTO. MD | | 24E. LOCATION (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS SWAN S. LEWIS + SON - 3319 OLYMPIA AVE | |



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H-125

BIRTH NO. 66 12520

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12520

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

EMERSON

HOF SOMMER

2. DATE AND HOUR PRONOUNCED DEAD

December 9, 1966

7:30 P

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION

31 Baltimore City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

Balt. Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

311 Dark Head Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

12/29/1917

9. AGE (In years
last birthday)

48

11. Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Machinist

10B. KIND OF BUSINESS OR INDUSTRY

Morton Co.

11. BIRTHPLACE (State or foreign country)

PA

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

John Hof Sommer

14. MOTHER'S MAIDEN NAME

Lillian Hughes

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

077-01-7398

17. INFORMANT

WIFE

ADDRESS

18.

223X

CAUSE OF DEATH

Intracerebral Hemorrhage
Arteriosclerotic Cardiovascular DiseaseINTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Ruptured angioma
DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breiteneker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/11/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Removal

23B. DATE

12/13/66

23C. NAME of CEMETERY or CREMATORY

German

23D. LOCATION

(City, town, or county)

(State)

Lacawana Long PA.

24A. DATE REC'D BY HEALTH DEPT.

DEC 10 1966

24B. NAME OF REGISTRAR

Robert E. Johnson

24C. FUNERAL DIRECTOR

J. J. Connolly

ADDRESS

300 more

Letter from M.E.'s office

3-9-67

M.H.

47-06-25 1B

F-SSO 66 12521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

66 12521

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

FINNAN, ELMER I

2. DATE AND HOUR OF DEATH

12-11-66

3:40

A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE, MARYLAND #212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND - BALTIMORE COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

ESSEX

D. STREET ADDRESS (If rural, give location)

908 WOODLYNN ROAD - #21221

5. SEX

MALE

6. RACE

WHITE

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

4-30-98

9. AGE (In years
lost birthday)

68

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

CLERK

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

JO

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

RECORDS-BCH-4940 EASTERN AVENUE-

18.

420.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) DUE TO

Respiratory arrest 2° Airway
obstruction 2° asphyxia

3-5 min

(B) DUE TO

Probable Myocardial Infarct

2-3 hr.

(C) DUE TO

ASCVD

unknown

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2 5

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

5

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-11-66 19 to 12-11-66 19
that (I) (we) last saw the deceased alive on 12-11-66 19 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

S.W. Douglas, III, M.D.

M.D.

Attending
Phys. ☐Med.
Director ☐Stoll
Phys. ☒

23B. DATE SIGNED

12-11-66

23C. PHYSICIAN'S
NAME (Type)

DR. S. W. DOUGLAS, III

M.D.

23D. ADDRESS

#21224

BCH-4940 EASTERN AVENUE-BALTIMORE, MD.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

12/11/66

24C. NAME OF CEMETERY or CREMATORY

Sacred Heart of Mary

24D. LOCATION

(City, town, or county)

Balto Md

(State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 15 1966

25B. NAME OF REGISTRAR

J. E. F. F. F.

25C. FUNERAL DIRECTOR

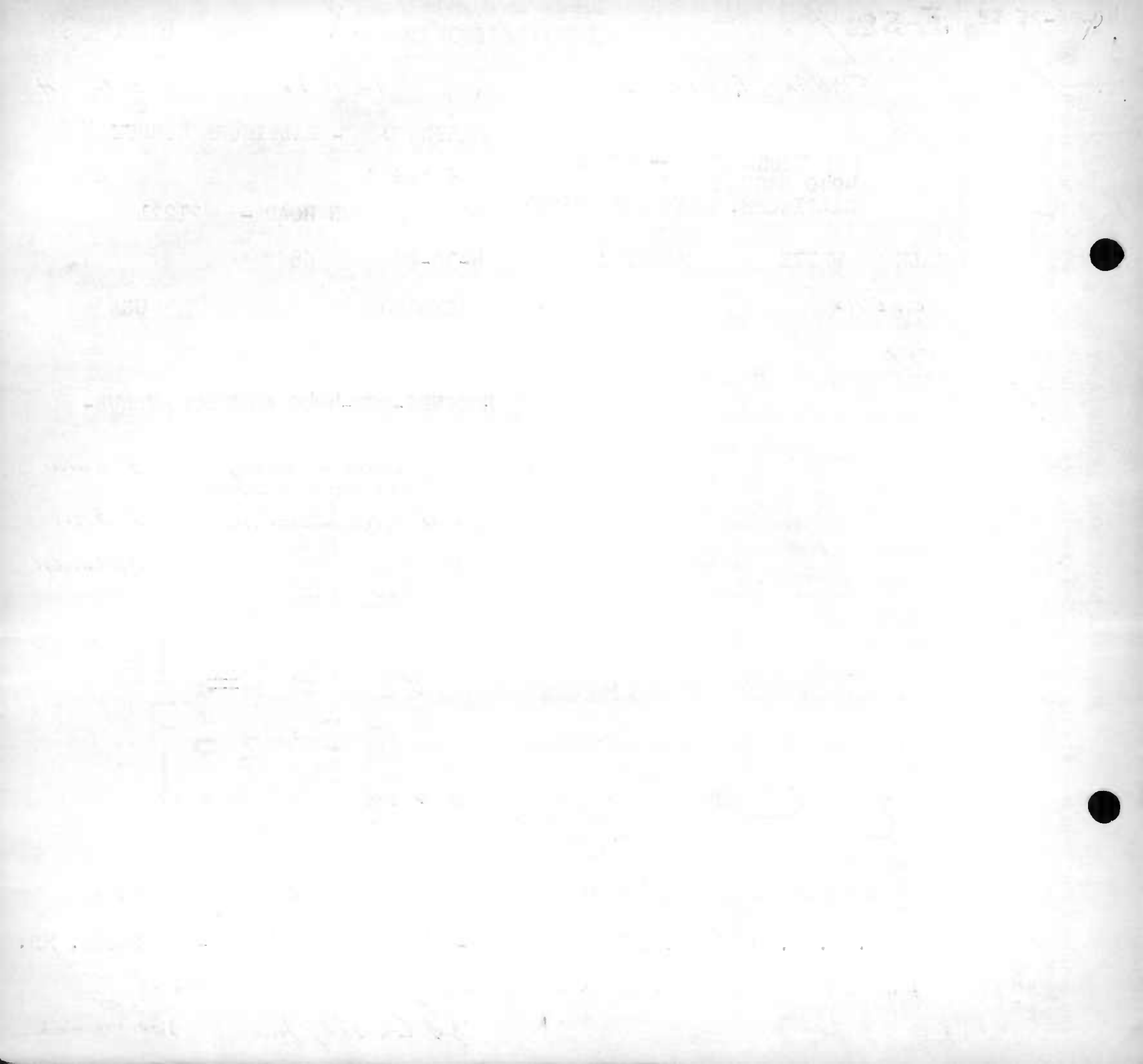
J. J. Connelly Sons

ADDRESS

300 more

FUNERAL DIRECTOR: IMPORTANT

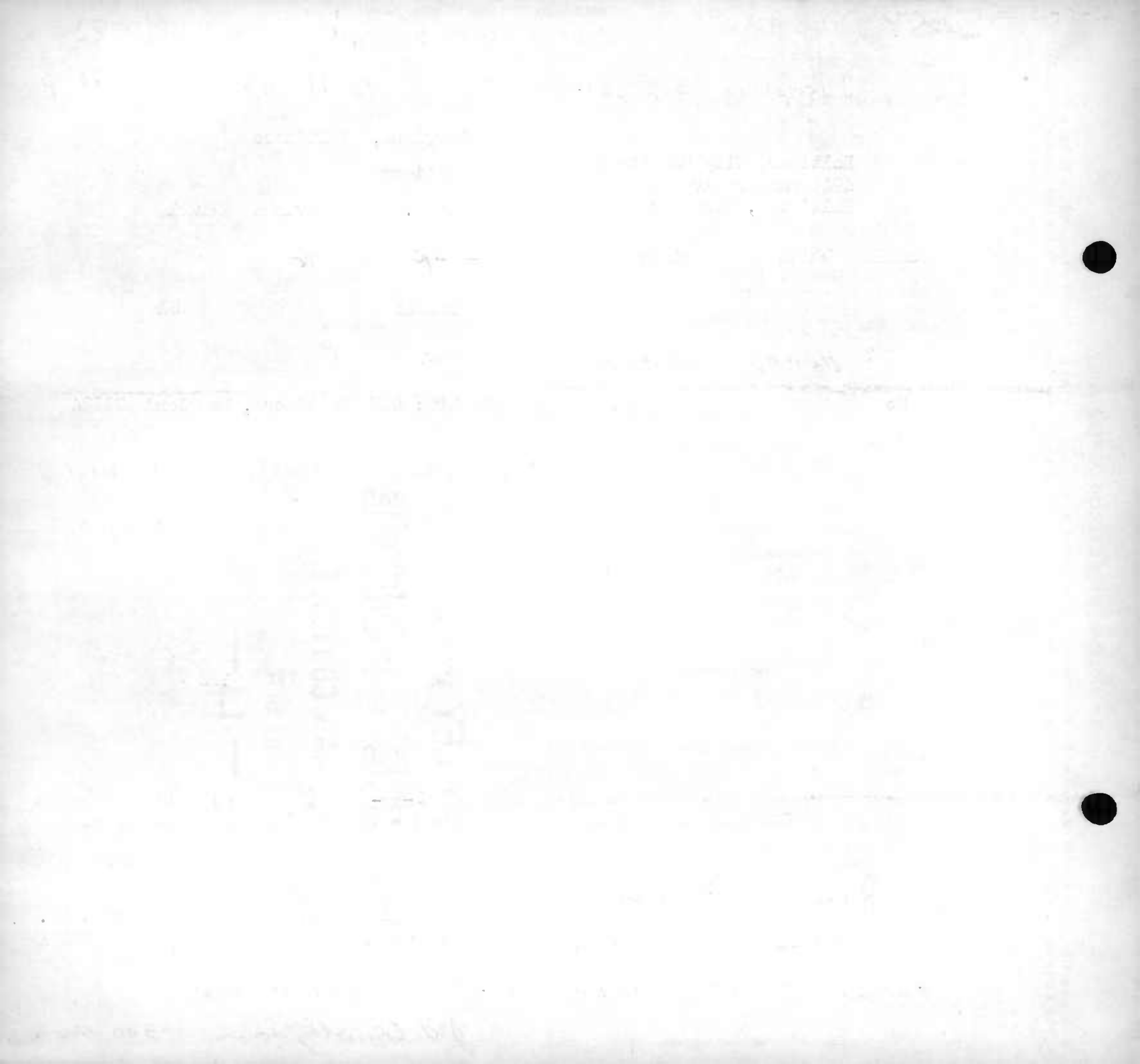
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|-------------------------|---|------------------------------------|--|---|---|--|
| BIRTH NO. 5-12 66 12522 | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 66 12522 | |
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) Josephine Simpson | | 2. DATE AND HOUR OF DEATH 12-11-66 1 30 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland, Baltimore B. COUNTY Baltimore | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland | | | | D. STREET ADDRESS (If rural, give location) 419 S. TAYLOR Avenue #21221 | | 53-00 | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow | 8. DATE OF BIRTH 3-24-90 | 9. AGE (In years lost birthday) 76 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Kansas | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME ? HENRY SHANE | | | | 14. MOTHER'S MAIDEN NAME Mary ? | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 22 | | 17. INFORMANT ADDRESS RECORDS: BCH Baltimore, Maryland #21224 | | | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Myocardial infarction DUE TO ASCVD DUE TO 10 yrs | | | | CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH 1 hr. | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-22-19 66 to 12-11-19 66 , that (I) (we) last saw the deceased alive on 12-11-19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Ross T. Krueger M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED | | | |
| 23C. PHYSICIAN'S NAME (Type) Ross T. Krueger M.D. | | | | 23D. ADDRESS 4940 Eastern Avenue Baltimore, Md. Baltimore City Hospital #21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/15/66 | | 24C. NAME of CEMETERY or CREMATORY SACRED HEART | | 24D. LOCATION (City, town, or county) (State) BALTO MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 15 1966 | | 25B. NAME OF REGISTRAR R. E. Johnson | | 25C. FUNERAL DIRECTOR J. H. Connolly Son | | ADDRESS 300 More | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|-------------------------|---|---|--|---|--|--|
| 48-27-87-1B | | 66 12523 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12523 | |
| M.E. CASE NO. 650 | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) FREDERICK S. GREEN | | | | 2. DATE AND HOUR OF DEATH 12-10-66 3⁰⁰ A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224 | | | | A. STATE MARYLAND - B. COUNTY BALTIMORE COUNTY | | | |
| (If not in hospital or institution, give street address or location) | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) ESSEX | | | |
| D. STREET ADDRESS (If rural, give location) 305 MACE AVENUE - #21221 | | | | 53-00 | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 8-26-09 | 9. AGE (In years lost birthday) 57 | If Under 1 Yr. Months | If Under 24 Hrs. Days | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Frederick Green, Sr. | | | 14. MOTHER'S MAIDEN NAME Mary BOSSK | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NAIK | | | 16. SOCIAL SECURITY NO. 215-07-1093 | | 17. INFORMANT ADDRESS RECORDS-BCH-4940 EASTERN AVE. 21224 | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) respiratory failure sev. hours ? MI ? CVA ? pneumonia emphysema | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ? congestive heart failure | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (this hospital) attended the deceased from 2 AM 12-10 1966 to 3 AM 12-10 1966 , that (we) last saw the deceased alive on 3 AM 12-10 1966 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Daniel C. Hadlock | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 10 December 1966 | |
| 23C. PHYSICIAN'S NAME (Type) DANIEL C. HADLOCK | | | | 23D. ADDRESS 1620 McEEDERRY ST. BALT., MD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/14/66 | | 24C. NAME OF CEMETERY or CREMATORY Sacred Heart | | 24D. LOCATION (City, town, or county) (State) Balto Md | |
| 25A. DATE REC'D. BY HEALTH DEPT. DEC 15 1966 | | 25B. NAME OF REGISTRAR Robert E. Salmon | | 25C. FUNERAL DIRECTOR J. J. Connelly Son | | ADDRESS 300 Mace | |

FEDERICK S. GREEN 12-10-90

reception of letters
from the
authorities

reception of letters

2 AM 12-10-90 3 AM 12-11-90

Daniel C. Harbeck
Daniel C. Harbeck

150 West 10th St., S.W., Wash., D.C.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------------------|---|---------------------------------------|--|---|
| BIRTH NO. 66 12524 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12524 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) EARNEST BOTTOM SR. | | 2. DATE AND HOUR OF DEATH 12-9-1966 2:50 PM | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION PROVIDENT HOSPITAL | | A. STATE MD B. COUNTY | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 13-04 | | | |
| | | D. STREET ADDRESS (If rural, give location) 1614 Gwynn Falls Pkwy | | | |
| 5. SEX M | 6. RACE Colored | 7. MARRIED, NEVER MARRIED MARRIED | 8. DATE OF BIRTH FEB 6-1910 | 9. AGE (In years lost birthday) 56 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) GALATIA N. C | |
| 13. FATHER'S NAME LEWY BOTTOM | | 14. MOTHER'S MAIDEN NAME Romie | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Romie Johnson 1634 Gwynn Falls Pkwy | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute coronary occlusion, Sudden | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | Radio Recenter Chest Unknown | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from July 4 1966 to Dec 9 1966 , that (I) (we) last saw the deceased alive on Dec 2 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE William H. Watt | | | | 23B. DATE SIGNED 12-12-66 | |
| 23C. PHYSICIAN'S NAME (Type) William H. Watt | | | | 23D. ADDRESS 515 N. Arlington Ave. Baltimore | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Removal 12/13/66 | | 24B. DATE 12/13/66 | | 24C. NAME OF CEMETERY or CREMATORY GALATIA N.C. | |
| 24D. LOCATION (City, town, or county) (State) | | 25A. DATE REC'D BY HEALTH DEPT. DEC 10 1966 | | 25B. NAME OF REGISTRAR Robert E. Taylor | |
| 25C. FUNERAL DIRECTOR Marshall P. Hays 638A. Gwynn Falls Pkwy | | 25D. ADDRESS 638A. Gwynn Falls Pkwy | | | |

Forest Bottoms. 12-9-1900 2 up

MD

Barren

1012 Campus Fair Spring

Foot up 20

Carata N.C. 11/4

Home

Home January 1884 (approx)

Frontier Hospital

M. (Good)

French

1012 Bottom

no

Carata N.C.

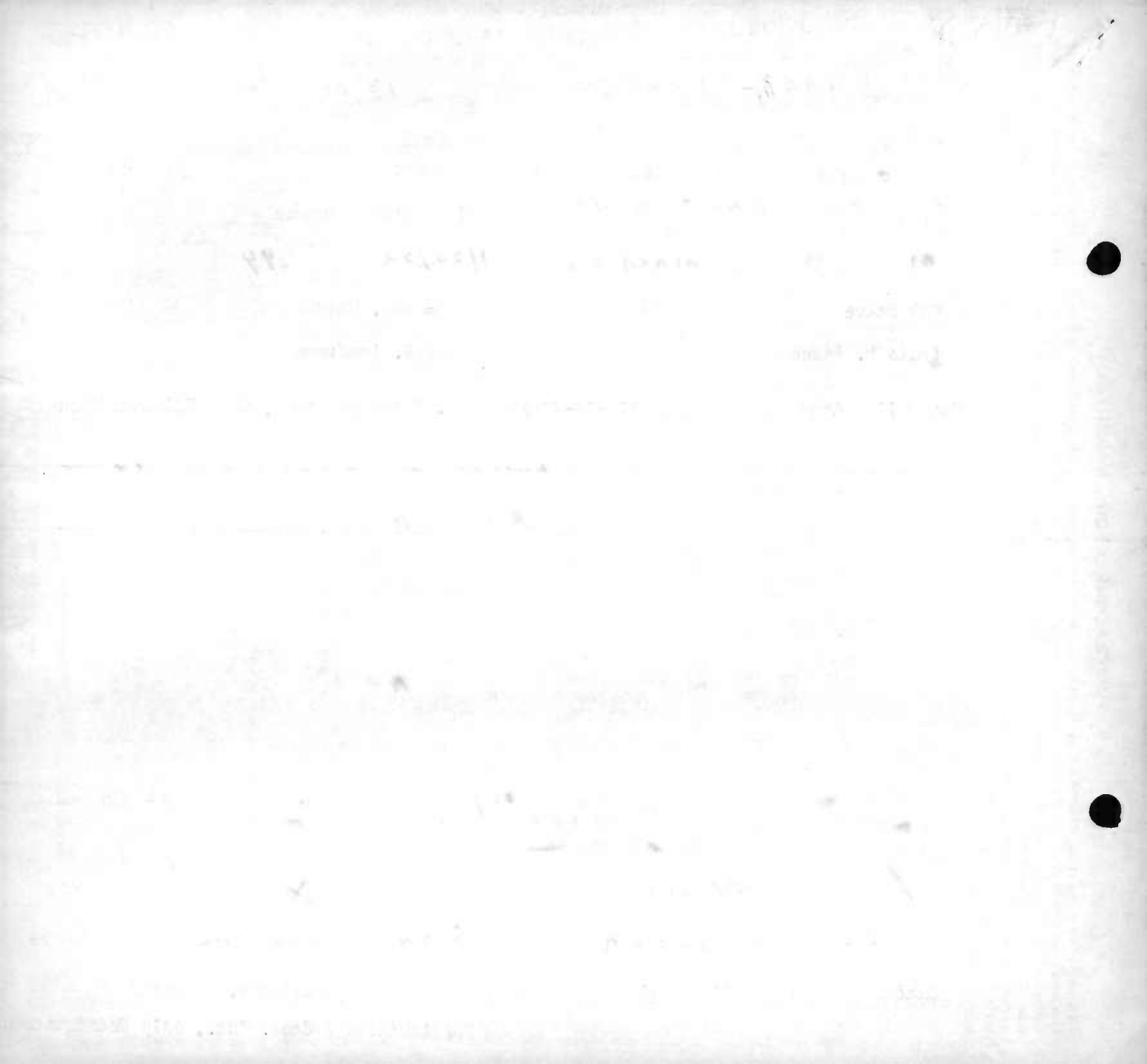
Mountain 1884 (approx)

Removal 1884

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|---------------------|---|---|--|---|---|--|--|--|
| 66 12525 | | | | | CERTIFICATE OF DEATH | | Registered No. 66 12525 | | |
| BIRTH-NO. 66 12525 | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED (Type or Print) FRANK-ALBERT | | | | | 2. DATE AND HOUR OF DEATH 13 DEC 1966 1 10²¹ A.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 42 SINAI HOSPITAL OF BALTIMORE | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) 28-31 | | | | |
| D. STREET ADDRESS (If rural, give location) 5410 Fairlawn Avenue | | | | | | | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 1/25/22 | 9. AGE (In years last birthday) 44 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab Drive | | | 10B. KIND OF BUSINESS OR INDUSTRY Diamond | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME Louis M. Frank | | | 14. MOTHER'S MAIDEN NAME Lena S. Landsman | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 11 Army | | | 16. SOCIAL SECURITY NO. 214-14-4785 | | 17. INFORMANT ADDRESS Mrs. Veronica Frank, 5410 Fairlawn Avenue | | | | |
| 18. I 4201 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) MYOCARDIAL INFARCTION DUE TO (B) ASCVD DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH 14 HRS | | | | | | | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that the (this hospital) attended the deceased from 12/12 19 66 to 12/13 19 66 , that the (we) last saw the deceased alive on 13 DEC 19 66 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. He (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Leon G. Sheer M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | | 23B. DATE SIGNED 13 DEC 1966 | | | | |
| 23C. PHYSICIAN'S NAME (Type) LEON G. SHEER M.D. | | | | | 23D. ADDRESS SINAI HOSPITAL OF BALTO. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/15/66 | | 24C. NAME OF CEMETERY or CREMATORY Mikro Kodesh Beth Israel | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 15 1966 | | 25B. NAME OF REGISTRAR DEC 15 1966 | | 25C. FUNERAL DIRECTOR ADDRESS Sol Levinson & Bros. Inc., 6010 Reisterstown | | | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|--|--|--|--|---|---|--|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 66 12526 | | | | |
| <div style="display: flex; justify-content: space-between;"> <div> DATE NO. 66 12526 M.E. CASE NO. S. </div> <div> 1. NAME OF DECEASED (Type or Print) HARRY RONKIN </div> <div> 2. DATE AND HOUR OF DEATH 12-13-66 2 45 P.M. </div> </div> | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND <div style="display: flex; justify-content: space-between;"> <div> FULL NAME OF HOSPITAL OR INSTITUTION 42 SINAI HOSPITAL of BALTIMORE, INC. </div> <div> 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-20 D. STREET ADDRESS (If rural, give location) 4008 PINKNEY Rd #15 </div> </div> | | | | | | | | | |
| 5. SEX Male | | 6. RACE white | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED | | 8. DATE OF BIRTH XXXXXXXXXX | | 9. AGE (In years last birthday) 60 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pet shop XXXXXXXXXX | | 10B. KIND OF BUSINESS OR INDUSTRY owner | | 11. BIRTHPLACE (State or foreign country) RUSSIA | | | 12. CITIZEN OF WHAT COUNTRY? USA. | | |
| 13. FATHER'S NAME Supply Samuel Rounkin | | | | | 14. MOTHER'S MAIDEN NAME Anna Brin | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) XXXXXXXXXX No | | | | | 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT ADDRESS Mr. Louis A. Rankin, 5904 Key Avenue | | |
| 18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div> (A) DUE TO COR Pulmonale (B) DUE TO PULMONARY EMPHYSEMA (C) </div> <div> INTERVAL BETWEEN ONSET AND DEATH </div> </div> | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 11/8/66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Tracheostomy - Resp. Distress | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-5-1966 to 12-13-1966, that (I) (we) last saw the deceased alive on 12-13-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Leslie Abramowitz | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-13-66 | | |
| 23C. PHYSICIAN'S NAME (Type) Leslie Abramowitz | | | | | 23D. ADDRESS SINAI HOSPITAL of BALTIMORE, INC. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/15/66 | | 24C. NAME of CEMETERY or CREMATORY Hebrew Young Men | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 15 1966 | | 25B. NAME OF REGISTRAR R. C. E. E. E. | | 25C. FUNERAL DIRECTOR Sol Levinson & Bros. Inc., 6010 Reisterstown | | ADDRESS | | | |

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1900

1900

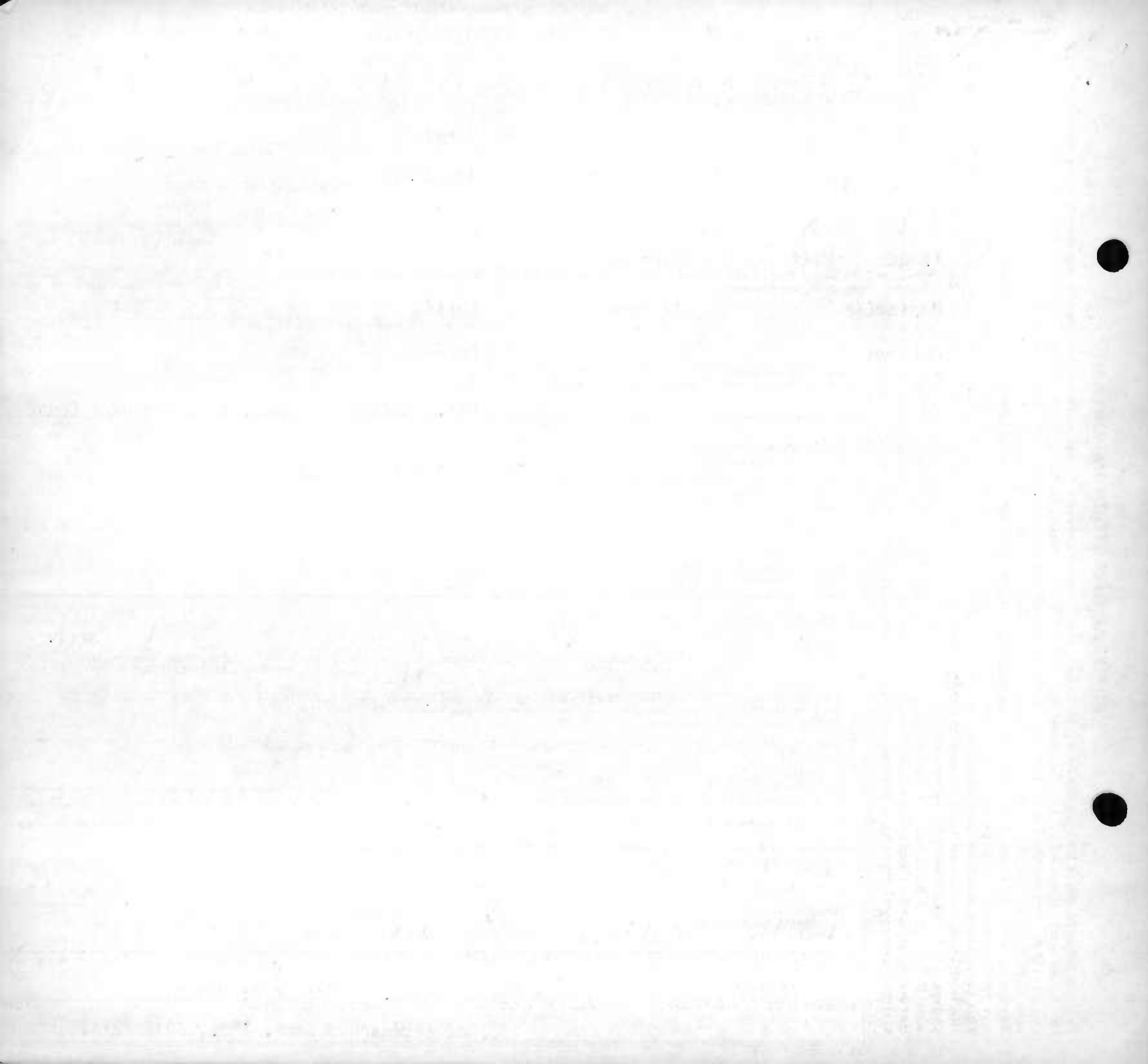
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

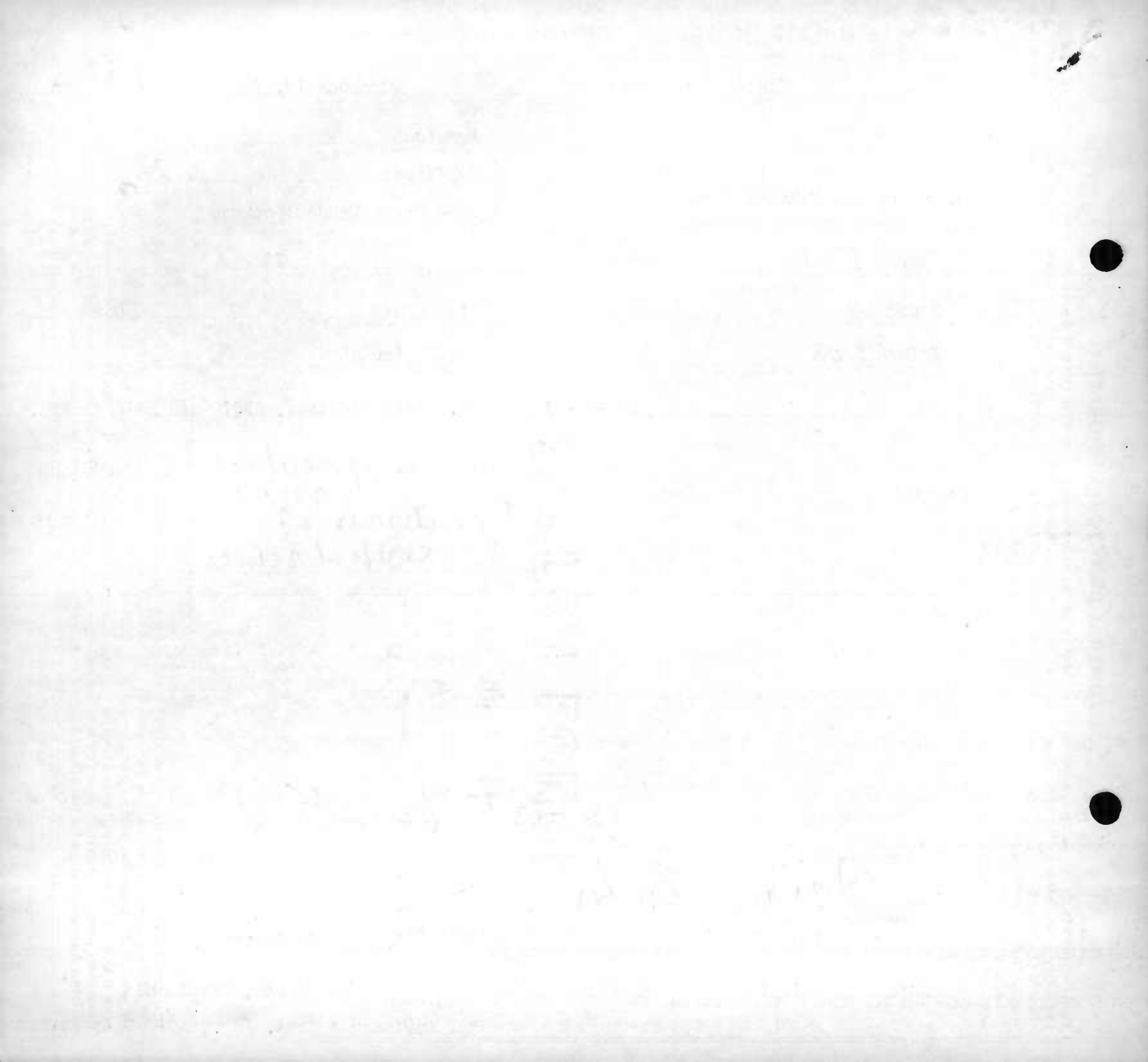
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. <u>66 12527</u> | |
|---|--------------------------------|--|---|--|---|---|--|
| M.E. CASE NO. <u>66 12527</u> 1. NAME OF DECEASED (Type or Print) <u>ZIMMERMAN, REBECCA</u> | | | | 2. DATE AND HOUR OF DEATH <u>12-13-66</u> <u>1</u> <u>7</u> ²⁵ <u>P</u> M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Levindale, Hebrew Home and Infirmary</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>27-17</u> D. STREET ADDRESS (If rural, give location) <u>Levindale Hebrew Home</u> | | | |
| 5. SEX <u>Female</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widowed</u> | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) <u>89</u> | If Under 1 Yr. Months _____ Days _____ If Under 24 Hrs. Hours _____ Min. _____ | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>At Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Russia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Unknown</u> | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>No</u> | | 17. INFORMANT <u>Mrs. William Solganik, 8047 Woodgate Court</u> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) <u>arteriosclerotic cardiovascular disease</u> (B) _____ (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Pneumonia</u> | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12-23-1959</u> to <u>12-13-1966</u> , that (I) (we) last saw the deceased alive on <u>12-13-1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Ruth Willmer</u> M.D. <input checked="" type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | | | 23B. DATE SIGNED <u>12-13-66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Ruth Willmer</u> M.D. | | | | | | 23D. ADDRESS <u>Levindale, Hebrew Home and Infirmary</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12/16/66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Progress Sick Relief Assoc.</u> | | 24D. LOCATION (City, town, or county) <u>Rosedale, Maryland</u> (State) _____ | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 20 1966</u> | | 25B. NAME OF REGISTRAR <u>James E. Taylor</u> | | 25C. FUNERAL DIRECTOR <u>Sol Levinson & Bros. Inc., 6010 Reisterstown</u> ADDRESS | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------|--|------------------|--|------------------------------|
| BIRTH NO. 66 12528 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12528 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| Jennie Rose Millison | | December 14, 1966 12 ³⁰ A M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| Belvedere Nursing Home | | Maryland | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 5950 Green Meadow Parkway | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. CITIZEN OF WHAT COUNTRY? |
| Female | White | Widowed | | 78 | USA |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Housewife | | At Home | | Lithuania | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| Zolman Sachs | | Bella Levin | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 220-46-8155 | | Mr. Harry Millison, 6301 Park Heights Ave. | |
| 18. 332X I | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) Thrombosis of cerebral vessel | | 3 weeks | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (B) Arteriosclerosis of cerebral vessels | | 5 years | |
| ANTECEDENT CAUSES | | (C) | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-21-1955 to 12-14-1966, that (I) (we) last saw the deceased alive on 12-13-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Irvin Sauber | | | | 12/14/66 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Irvin Sauber | | 6905 Park Heights Avenue | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 12/15/66 | | Beth Tishoh | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| DEC 15 1966 | | R. E. Johnson | | Sol Levinson & Bros. Inc., 6010 Reisterstown | |



FUNERAL DIRECTOR: IMPORTANT

Notarized by Dr. John Holmes III

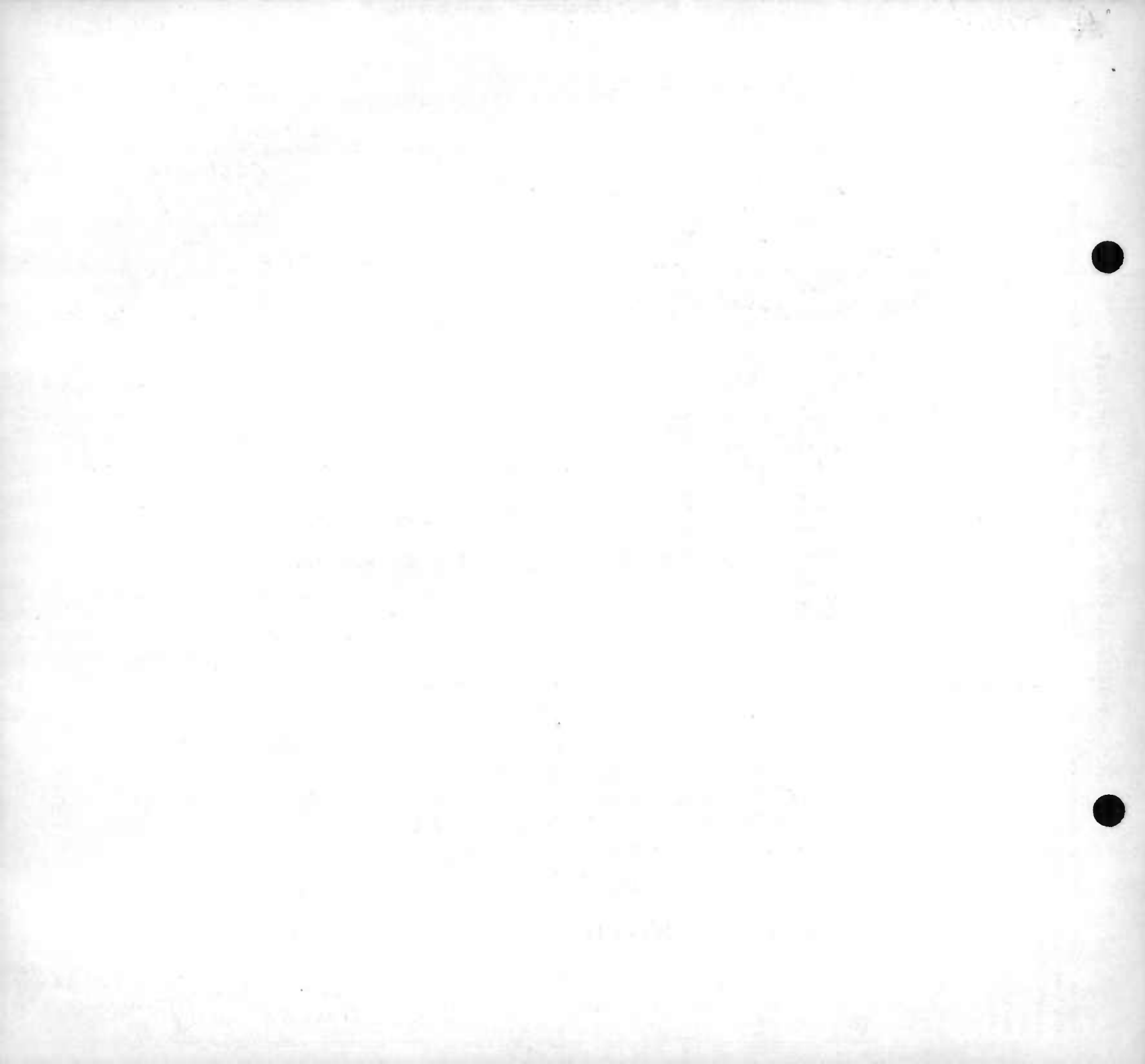
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------------------------|---|---|--|--|
| BIRTH NO. 66 12529 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12529 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Jesse Jackson Lee</i> | | 2. DATE AND HOUR OF DEATH <i>9 Dec. 1966 9:53 P.M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Lutheran Hosp.</i> | | A. STATE <i>Maryland</i> B. COUNTY | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 16-05</i> | | | |
| | | D. STREET ADDRESS (If rural, give location) <i>1003 Wheelw Ave.</i> | | | |
| 5. SEX <i>Male</i> | 6. RACE <i>Colored</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i> | 8. DATE OF BIRTH <i>22 Apr. 1907</i> | 9. AGE (In years last birthday) <i>59</i> | If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Shipping Clerk</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Clothing</i> | | 11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i> | |
| 13. FATHER'S NAME <i>Claude J. Lee</i> | | 14. MOTHER'S MAIDEN NAME <i>Priscilla Phillips</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes 28 May 1942 - 9 Aug. 1945</i> | | 16. SOCIAL SECURITY NO. <i>431-10-8312</i> | | 17. INFORMANT'S NAME AND ADDRESS <i>Ms. Betty Reed Lee 1003 Wheelw Ave.</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>443X</i> | | CAUSE OF DEATH (A) DUE TO <i>hypertensive Cardiovascular disease</i> (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH <i>unknown</i> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>NO</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>January</i> 19 <i>66</i> to <i>December</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>December 6</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Royston B. Scott</i> | | | | 23B. DATE SIGNED <i>Dec 12, 66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>ROYSTON B. SCOTT</i> | | | | 23D. ADDRESS <i>1801 W BALTIMORE BALTIMORE, MD</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>14 Dec. 1966</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Balt. Nat'l. Baltimore, Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 15 1966</i> | | 25B. NAME OF REGISTRAR <i>Robert E. [illegible]</i> | | 25C. FUNERAL DIRECTOR <i>Halland Funeral Home 1001 Druid Hill Ave.</i> | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|--|--|--|--|--|--|--|-------------------------|---|----------------|--|
| 66 12530 | | | | | CERTIFICATE OF DEATH | | Registered No. 66 12530 | | | |
| <div style="display: flex; justify-content: space-between;"> <div> BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <i>Aguilano Carrie</i> </div> <div> 2. DATE AND HOUR OF DEATH <i>12-11-66 9.35 A.M.</i> </div> </div> | | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND <div style="display: flex; justify-content: space-between;"> <div> FULL NAME OF HOSPITAL OR INSTITUTION <i>42 Sinai Hospital of Baltimore</i> </div> <div> 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Baltimore, Maryland</i> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> </div> </div> | | | | | 5. SEX <i>female</i> 6. RACE <i>white</i> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widow</i> | | | | | |
| 8. DATE OF BIRTH <i>9-30-1902</i> 9. AGE (In years lost birthday) <i>64</i> | | | | | 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Machine operator Tailoring</i> 10B. KIND OF BUSINESS OR INDUSTRY <i>Italy</i> | | | | | |
| 11. BIRTHPLACE (State or foreign country) <i>Italy</i> 12. CITIZEN OF WHAT COUNTRY? <i>America</i> | | | | | 13. FATHER'S NAME <i>Anthony Rizzo</i> 14. MOTHER'S MAIDEN NAME | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> 16. SOCIAL SECURITY NO. <i>213-18-9517</i> | | | | | 17. INFORMANT <i>RITA GERMAN</i> ADDRESS <i>2319 Derby Road</i> | | | | | |
| 18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i> </div> <div> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) <i>Massive G-I Bleeding</i> (B) <i>CVA</i> (C) <i>Diabetes mellitus</i> </div> </div> | | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | |
| MEDICAL CERTIFICATION <div style="display: flex; justify-content: space-between;"> <div> 19A. DATE OF OPERATION <i>11-11-66</i> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>diabetic orthopedic gangrene of left foot</i> </div> <div> 20A. AUTOPSY? (Yes or No) <input type="checkbox"/> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? </div> </div> | | | | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>11-8</i> 19 <i>66</i> to <i>12-11</i> 19 <i>66</i> , that (I) (we) lost saw the deceased alive on <i>12-11, 9:35 AM</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE <i>Pyong IL KWON</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | | 23B. DATE SIGNED <i>12-11-66</i> | | | | | |
| 23C. PHYSICIAN'S NAME (Type) <i>PYONG IL KWON</i> M.D. | | | | | 23D. ADDRESS <i>Sinai Hosp</i> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | | 24B. DATE <i>12-14-66</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>BALTIMORE NATIONAL</i> | | | 24D. LOCATION (City, town, or county) (State) <i>Frank H Seitz 814 W 36 St</i> | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 15 1966</i> | | | 25B. NAME OF REGISTRAR <i>R. E. E. E.</i> | | | 25C. FUNERAL DIRECTOR <i>BALTIMORE MD</i> | | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 12531</u> | |
|---|--|--|--|--|--|
| BIRTH NO. <u>66 12531</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Bessie E. Heavel</u> | | 2. DATE AND HOUR OF DEATH <u>12/11/66</u> <u>11 A.M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>00</u> | | (If not in hospital or institution, give street address or location) <u>3434 Chestnut Avenue</u> <u>Baltimore, Maryland 21211</u> | | A. STATE <u>Md.</u> B. COUNTY | |
| 5. SEX <u>F</u> | | 6. RACE <u>White</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u> | |
| 8. DATE OF BIRTH <u>Jan 19, 1920</u> | | 9. AGE (In years lost birthday) <u>46 yrs</u> | | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S. A</u> | | 13. FATHER'S NAME <u>Claud Slonaker</u> | | 14. MOTHER'S MAIDEN NAME | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>212-14-1577</u> | | 17. INFORMANT <u>Melvin L. Heavel</u> <u>3434 Chestnut Ave. 21211</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) <u>Cancer of cervix + uterus</u> | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Pneumonia bilateral</u> | | <u>1 wk</u> | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>February 8, 1966</u> to <u>December 11, 1966</u> , that (I) (we) lost s/he the deceased alive on <u>December 11, 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Herman Brecher</u> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>12/12/66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Herman Brecher</u> | | 23D. ADDRESS <u>443 East 25th Street - Balto, Md.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12/15-1966</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Lorraine Pk. Cemetery</u> | |
| 24D. LOCATION <u>Baltimore</u> | | 24E. LOCATION <u>Baltimore</u> | | 24F. LOCATION <u>Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 15 1966</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR <u>Frank H. Leitz 814 W 36 St.</u> | |

66 12532

BALTIMORE CITY HEALTH DEPARTMENT

66 12532

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM H. FICKES

2. DATE AND HOUR PRONOUNCED DEAD

12-12-66

7:50 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

ST. AGNES HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY Balt. Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5931 Johnnycake Road 21228

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

July 13, 1911

9. AGE (In years
last birthday)

55

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Chief draftsman

10B. KIND OF BUSINESS OR INDUSTRY

Bethlem Steel

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Late - Alfred C. Fickes

14. MOTHER'S MAIDEN NAME

Abilgail

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

097-10-6815

17. INFORMANT

Mrs. Olive G. Fickes
5931 Johnnycake Rd.

ADDRESS

18. E8234

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Multiple injuries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Highway

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Baltimore National Pike and
Greenwish Road21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
12 12 '66 7:25
AM

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Driver of auto which ran off road and
struck pole

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

WERNER U. SPITZ M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-12-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12-15-66

23C. NAME of CEMETERY or CREMATORY

Lakeview Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Witzke F.D.-4101 Edmondson Ave.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **66 12533**

BIRTH NO. **66 12533**

M.E. CASE NO. **66 12533**

1. NAME OF DECEASED (Type or Print) **JAMES L. ROHRBACH**

2. DATE AND HOUR PRONOUNCED DEAD **12-12-66 11:00 A.M.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland**
B. COUNTY **Baltimore**

5. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
00 1218 W. BALTIMORE STREET

6. CITY OR TOWN (If outside corporate limits, with RURAL and give township)
Baltimore

7. STREET ADDRESS (If rural, give location)
1218 W. Baltimore Street

8. SEX **Male**

9. RACE **White**

10. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **Single**

11. DATE OF BIRTH **July 16, 1915**

12. AGE (in years last birthday) **51**

13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Clerk**

14. KIND OF BUSINESS OR INDUSTRY **Commercial Credit**

15. BIRTHPLACE (State or foreign country) **Maryland**

16. CITIZEN OF WHAT COUNTRY? **USA**

17. FATHER'S NAME **Jacob Rohrbach**

18. MOTHER'S MAIDEN NAME **Catherine Weisinger**

19. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) **yes WW II**

20. SOCIAL SECURITY NO.

21. INFORMANT **Mr. Norris Rohrbach 4733 Dartford Ave.**

22. ADDRESS

23. CAUSE OF DEATH

24. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Arteriosclerotic cardiovascular disease

25. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

26. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

27. MEDICAL CERTIFICATION

28. 19A. DATE OF OPERATION **0**

29. 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

30. 20A. AUTOPSY? (Yes or No) **No**

31. 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

32. 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

33. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

34. 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

35. 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

36. 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

37. 21F. HOW DID INJURY OCCUR?

38. 22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: **Natural causes** ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

39. ACTUAL SIGNATURE **Werner U. Spitz, M.D.**

40. EXAMINER'S NAME (Type) **WERNER U. SPITZ, M.D.**

41. CHIEF MEDICAL EXAMINER ☐

42. M.D. ASSISTANT MEDICAL EXAMINER ☒

43. ASSOCIATE MEDICAL EXAMINER ☐

44. DATE SIGNED **12-12-66**

45. 23A. BURIAL CREMATION, REMOVAL (Specify) **Burial**

46. 23B. DATE **12-15-66**

47. 23C. NAME OF CEMETERY or CREMATORY **Loudon Park Cem.**

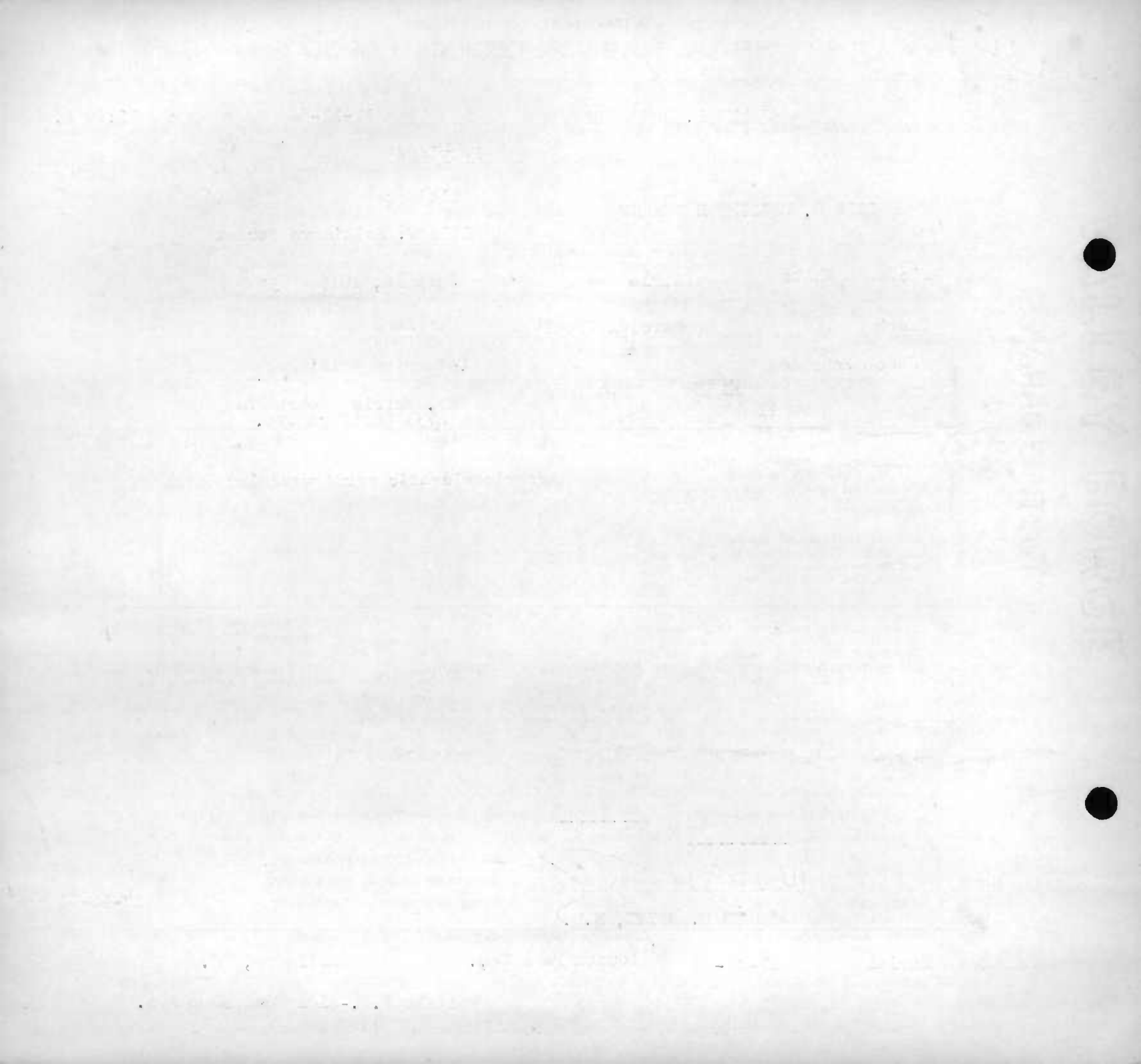
48. 23D. LOCATION (City, town, or county) (State) **Baltimore, Md.**

49. 24A. DATE REC'D BY HEALTH DEPT. **DEC 15 1966**

50. 24B. NAME OF REGISTRAR **W. E. F. F.**

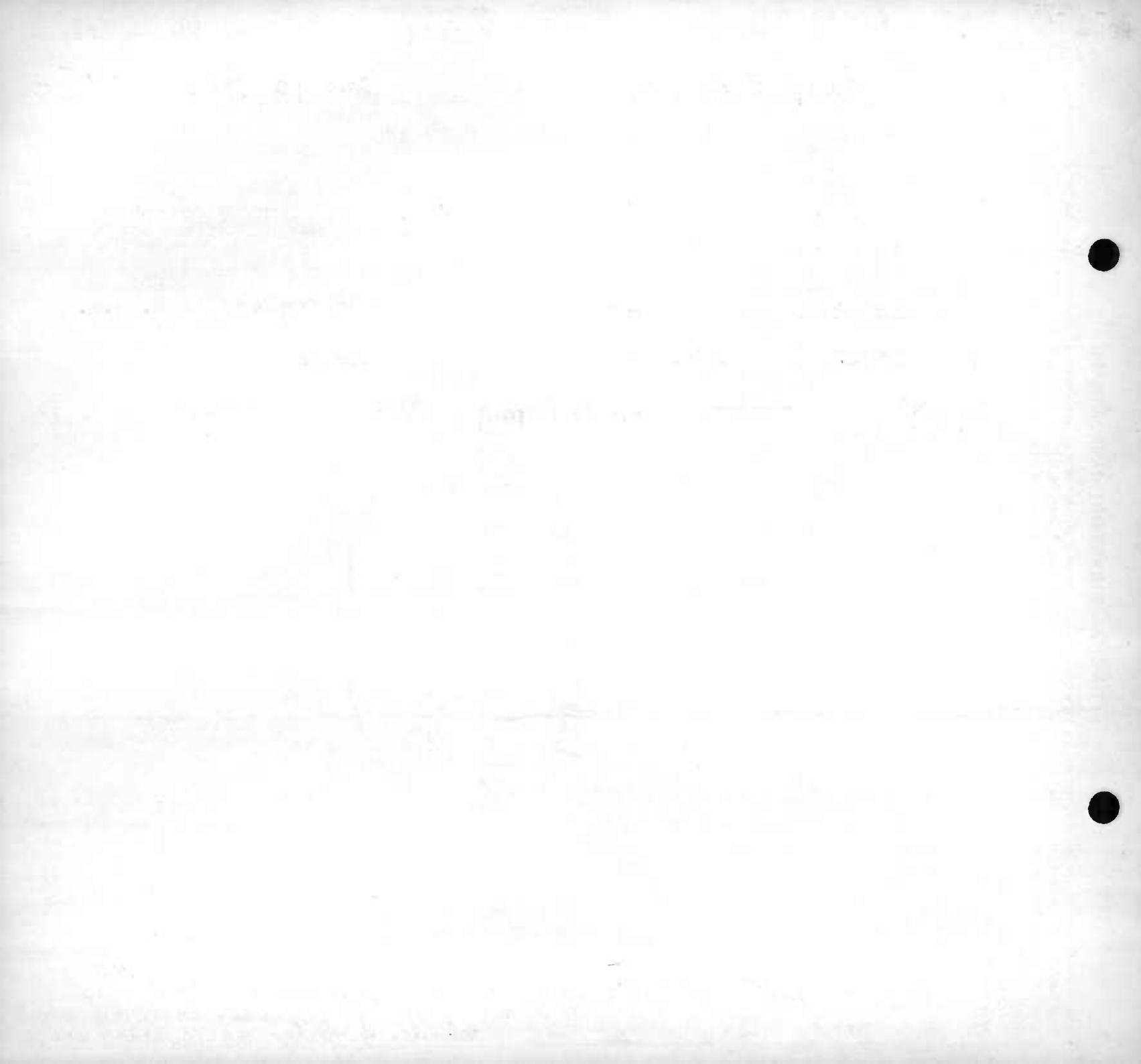
51. 24C. FUNERAL DIRECTOR **Witzke F.D.-4101 Edmondson Ave.**

52. ADDRESS



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

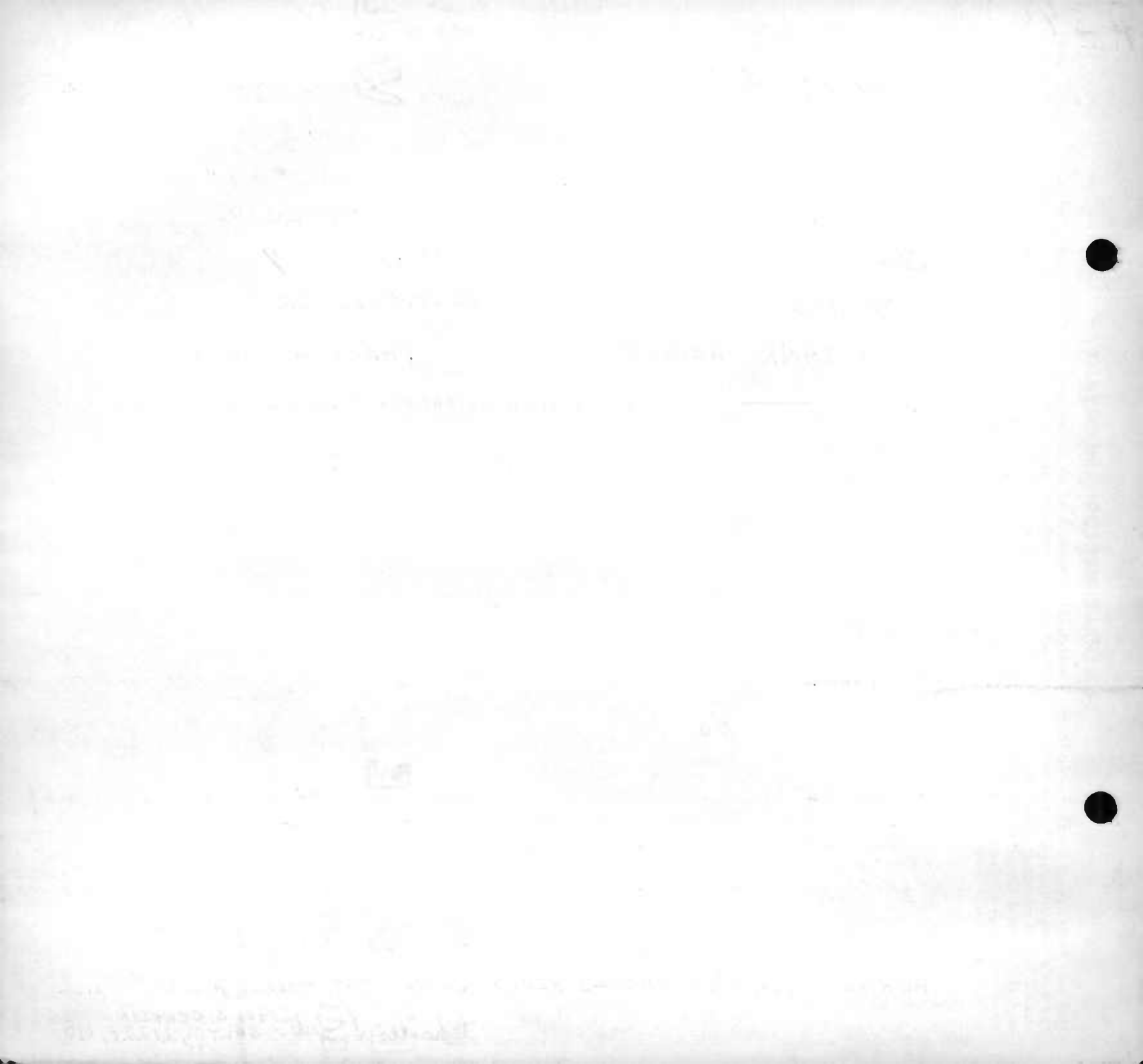
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12534 | |
|--|--|--|--|---|--|
| BIRTH NO. 66 12534 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Rau, Edna M., | | | | Dec. 12, 1966 8 45 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224 | | | | A. STATE MARYLAND B. COUNTY BALTIMORE | |
| 5. SEX Female | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | |
| 6. RACE White | | | | D. STREET ADDRESS (If rural, give location) 638 S. OLDHAM STREET 21224 | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | | | | 9. AGE (In years lost birthday) 68 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK | | | | 11. BIRTHPLACE (State or foreign country) MARYLAND, BALTIMORE | |
| 10B. KIND OF BUSINESS OR INDUSTRY AT HOME | | | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME BOLDEN | | | | 14. MOTHER'S MAIDEN NAME MILDRED | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. 216-10-7046A | |
| 17. INFORMANT BCH | | | | ADDRESS RECORDS: 4940 Eastern Avenue 21224 | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | INTERVAL BETWEEN ONSET AND DEATH 2 1/2 wks | |
| 19A. DATE OF OPERATION O | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) No | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 11-24-66 to 12-12-66, that (1) (we) last saw the deceased alive on 12-12-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Ross T. Krueger | | | | 23B. DATE SIGNED 12-12-66 | |
| 23C. PHYSICIAN'S NAME (Type) Ross T. Krueger | | | | 23D. ADDRESS 4940 Eastern Avenue 21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | | 24B. DATE 12-15-66 | |
| 24C. NAME of CEMETERY or CREMATORY OAK LAWN CEM. | | | | 24D. LOCATION 7225 EASTERN BLVD. BALTO. CO., MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 15 1966 | | | | 25B. NAME OF REGISTRAR Charles E. Taberna | |
| 25C. FUNERAL DIRECTOR Charles E. Taberna | | | | 25D. ADDRESS 6224 EASTERN AVE. BALTO., MD. | |



FUNERAL DIRECTOR: IMPORTANT

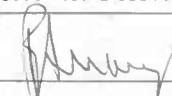
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

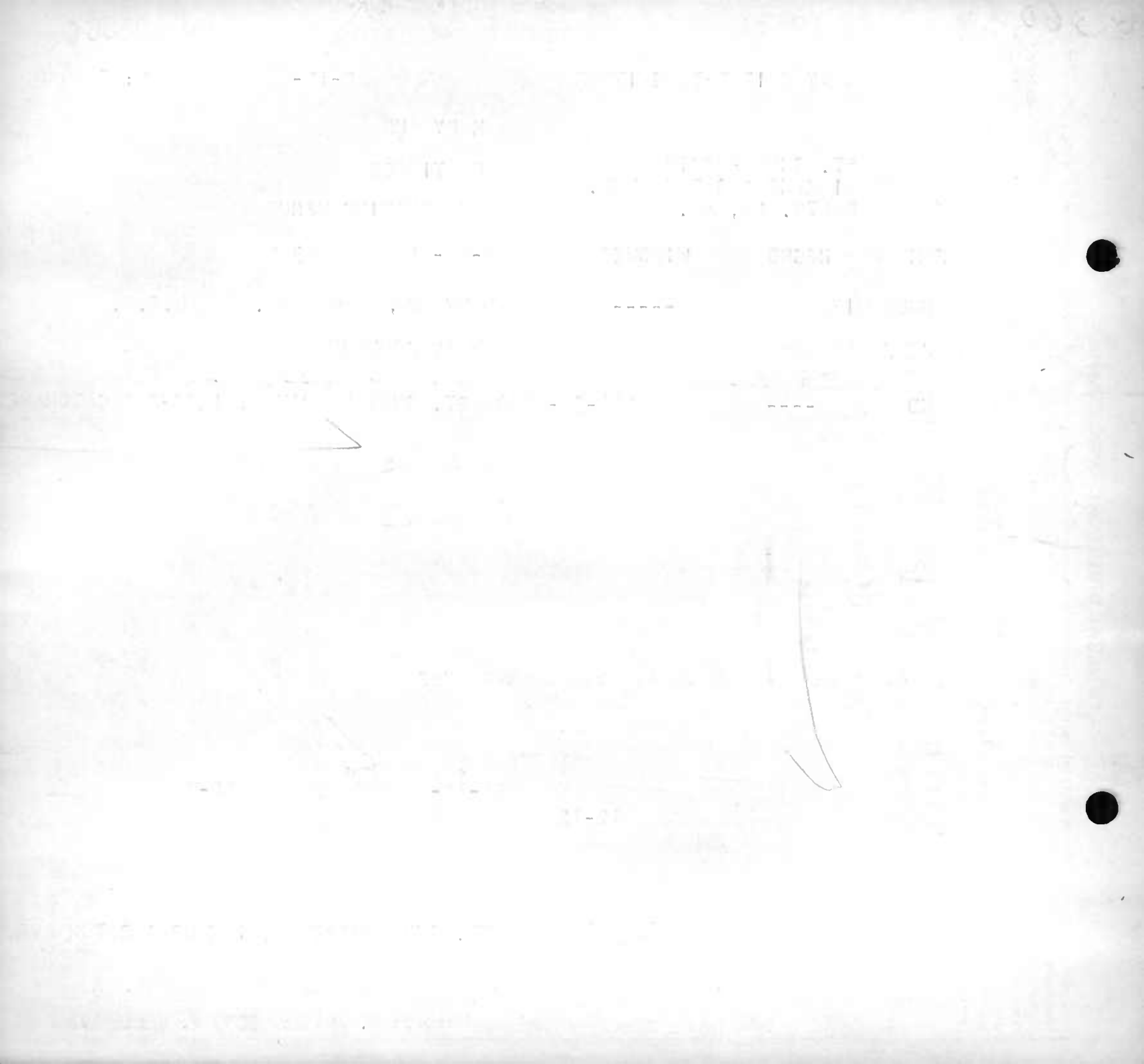
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12535 | |
|---|-----------------------------|---|-------------------------------------|--|--|
| BIRTH NO. 66 12535 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Michael S. Heinkle</i> | | 2. DATE AND HOUR OF DEATH <i>Dec. 12, 1966 11:10 PM</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>BALTO. CITY</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>SOUTH BALTIMORE GEN. HOSP</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE #21230.</i> | | | |
| (If not in hospital or institution, give street address or location) | | D. STREET ADDRESS (If rural, give location) <i>511 S. MANOVER ST.</i> | | | |
| 5. SEX <i>Male</i> | 6. RACE <i>Caucasian</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Separated</i> | 8. DATE OF BIRTH <i>1-25-97.</i> | 9. AGE (In years last birthday) <i>69</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>-</i> | | 11. BIRTHPLACE (State or foreign country) <i>BALTTMORE, MD.</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i> | | 13. FATHER'S NAME <i>FRANK HEINLE</i> | | 14. MOTHER'S MAIDEN NAME <i>THERESA SELIG</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i> | | 16. SOCIAL SECURITY NO. <i>215-07-4226A</i> | | 17. INFORMANT <i>ELIZABETH C. HEINLE</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>CAUSE OF DEATH</i> <i>Pulmonary Abscess</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>NOT KNOWN</i> | | 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | |
| 19A. DATE OF OPERATION <i>None</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>-</i> | | 20A. AUTOPSY? (Yes or No) <i>Yes</i> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Not Available yet</i> | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>-</i> | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (H) (this hospital) attended the deceased from <i>11-30</i> 19 <i>66</i> to <i>12-12</i> 19 <i>66</i> , that (H) (we) last saw the deceased alive on <i>12-12</i> 19 <i>66</i> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <i>William F. Bruther</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>12-12-66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>William F. Bruther</i> | | 23D. ADDRESS <i>1213 Light Street</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 24B. DATE <i>12-15-66</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>SACRED HEART CEM.</i> | |
| 24D. LOCATION (City, town, or county) <i>BALTO. CO., MD.</i> | | 24E. LOCATION (City, town, or county) <i>7401 GERMAN HILL RD.</i> | | 24F. LOCATION (City, town, or county) <i>BALTO. CO., MD.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 15 1966</i> | | 25B. NAME OF REGISTRAR <i>R. E. E. E.</i> | | 25C. FUNERAL DIRECTOR <i>Charles S. Jailer</i> | |
| 25D. ADDRESS <i>901 S. CONKLING ST. BALTO., 21224, MD.</i> | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12536 | |
|--|------------------|--|-----------------------------|--|---|
| BIRTH NO. 66 12536 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) MARY ELIZABETH GAITHER | | 2. DATE AND HOUR OF DEATH 12-12-66 2:05 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY Balto. Co. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-00 | |
| FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL WILKENS & CATON AVEN. BALTO. 29, MD. | | D. STREET ADDRESS (If rural, give location) 106 FUSTING AVENUE | | | |
| 5. SEX FEMALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 1-29-93 | 9. AGE (In years last birthday) 73 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY ----- | | 11. BIRTHPLACE (State or foreign country) MARYLAND, Howard Co. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME JOHN HAMMOND | | 14. MOTHER'S MAIDEN NAME MARY JOHNSON | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 214-56-1174 | | 17. INFORMANT ADDRESS ST. AGNES HOSPITAL, WILKENS & CATON AVE. | |
| 18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Diabetic Acidosis DUE TO (B) Diabetes & ASCVD DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 3-11-66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Diabetic Gangrene | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 11-11-66 to 12-12-66, that (I) (we) last saw the deceased alive on 12-12-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE  | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-12-66 | |
| 23C. PHYSICIAN'S NAME (Type) RAMON U. SUAREZ | | 23D. ADDRESS M.D. ST. AGNES HOSPITAL, WILKENS & CATON AVE. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Dec 16, 1966 | | 24C. NAME OF CEMETERY OR CREMATORY Western Star Cemetery | |
| 24D. LOCATION Catonsville Balto Co. Md | | 25A. DATE REC'D BY HEALTH DEPT. DEC 15 1966 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS Herbert E. Nutter 3035 W. North Ave | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|-------------------------|---|------------------------------------|--|---|--|--|
| BIRTH NO. 66 12537 | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 66 12537 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Joseph Dorsey | | | | 2. DATE AND HOUR OF DEATH 12-10-66 12:50AM. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 39 Provident Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 16-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, D. STREET ADDRESS (If rural, give location) 705 N. Calhoun Street | | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Separated | 8. DATE OF BIRTH 3-10-14 | 9. AGE (In years lost birthday) 52 yrs. | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10B. KIND OF BUSINESS OR INDUSTRY Empire Paper Co | | 11. BIRTHPLACE (State or foreign country) Balto., Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Joseph Dorsey | | | | 14. MOTHER'S MAIDEN NAME Louisa Brown | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 216-01-7187 | | 17. INFORMANT Mrs. Genevieve Hutto | | ADDRESS SAME | |
| 18. 500X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) 1 Pneumonia DUE TO (B) 2 Pulmonary edema DUE TO (C) 3 Acute Bronchitis | | INTERVAL BETWEEN ONSET AND DEATH from 12/9/66 through 12/10/66 | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from December 9, 1966 to December 10, 1966 , that (I) (we) last saw the deceased alive on December 10, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE  M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED 12-10-66 | | | |
| 23C. PHYSICIAN'S NAME (Type) C. Laredo, M.D. | | | | 23D. ADDRESS 1514 Division Street Balto., Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Dec 15, 1966 | | 24C. NAME of CEMETERY or CREMATORY Mount Auburn Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 15 1966 | | 25B. NAME OF REGISTRAR R. E. E. E. | | 25C. FUNERAL DIRECTOR Herbert E. Nutter 3035 W. North Ave | | | |

47-85-75

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

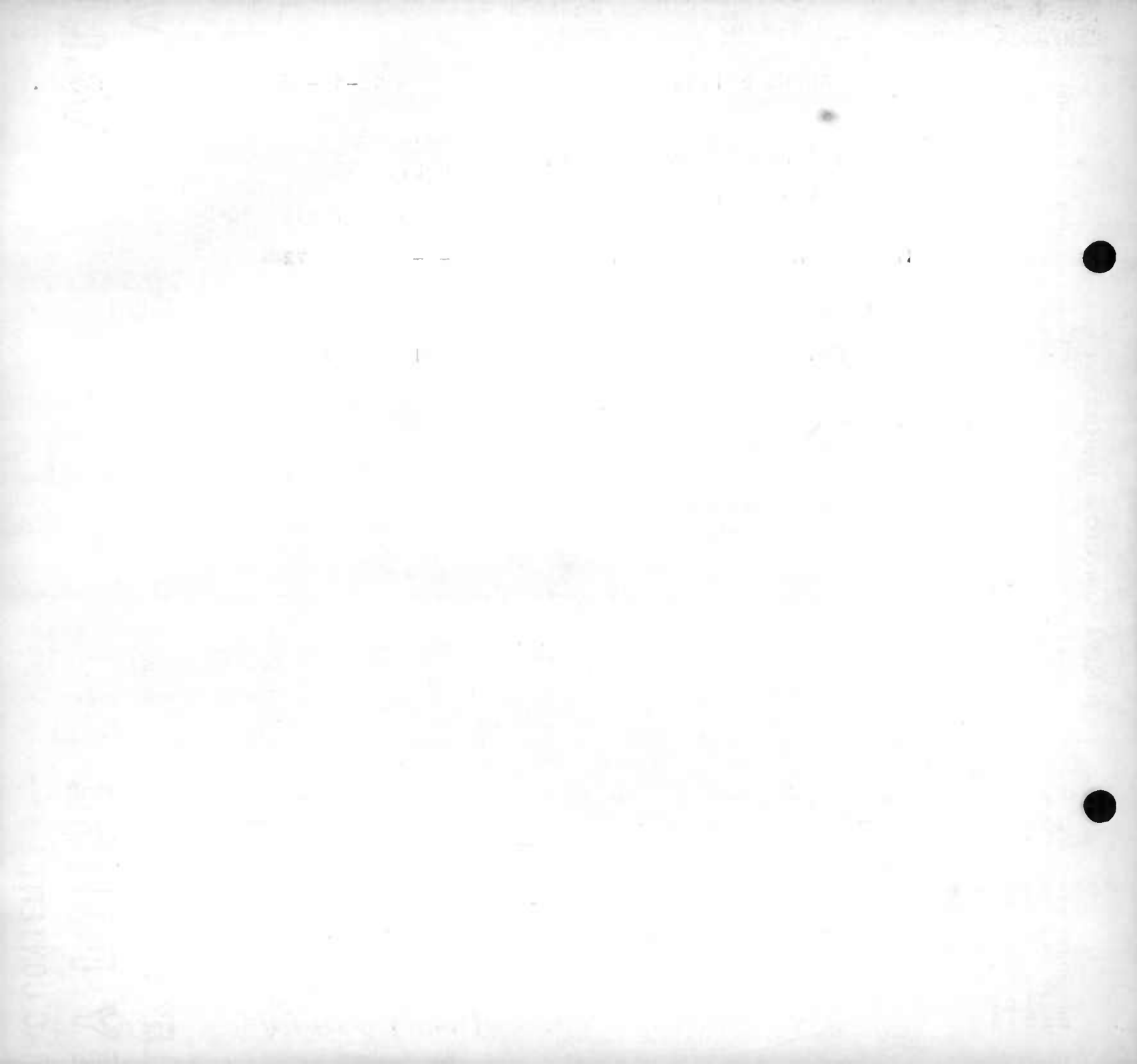
| BIRTH NO. 66 12538 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12538 | |
|---|------------------|---|------------------------------|--|---|--|---|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) MARY OLIVER | | | | 2. DATE AND HOUR OF DEATH 12/10/66 8:15 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224 | | | | A. STATE MARYLAND B. COUNTY 16-06 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2736 EDMONDS ON AVENUE #21223 | | | |
| 5. SEX FEMALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 12/25/08 | 9. AGE (In years last birthday) 57 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | 11. BIRTHPLACE (State or foreign country) VIRGINIA, Charlottesville | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME WILLIE POLLARD | | | | 14. MOTHER'S MAIDEN NAME BETTY SMITH | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. 215-22-6713 | | 17. INFORMANT RECORDS: BGH 4940 EASTERN AVENUE #21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) DUE TO CUA DIABETES MELLITUS (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 2 days MANY YEARS | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | Kimmelstiel Wilson Kidney & (B) | | | |
| 19A. DATE OF OPERATION 10/18/66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Heart mass | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/11/66 to 12/10/66, that (I) (we) last saw the deceased alive on 12/10/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE David Swimmer | | | | 23B. DATE SIGNED 12-10-66 | | 23C. PHYSICIAN'S NAME (Type) DR. DAVID SWIMMER | |
| 23D. ADDRESS M.D. 4940 EASTERN AVENUE #21224 | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Dec 16, 1966 | | 24C. NAME of CEMETERY or CREMATORY Mount Auburn Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 15 1966 | | 25B. NAME OF REGISTRAR R. E. E. Taylor | | 25C. FUNERAL DIRECTOR Herbert E. Nutter 3035 W. North Ave | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

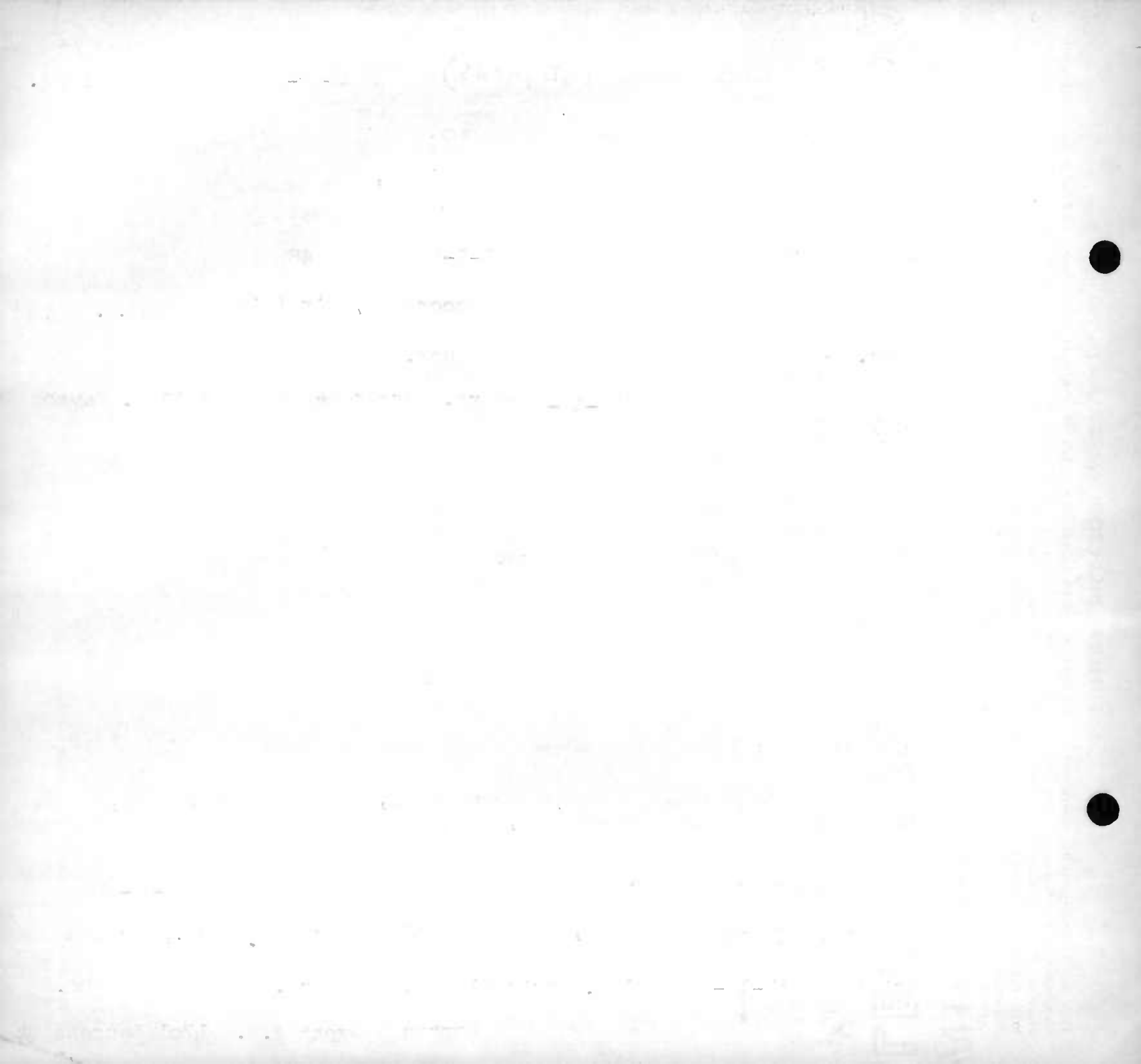
| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. 66 12539 | | REGISTERED NO. 66 12539 | |
|---|---------------------|---|-----------------------------------|--|---|--|--|
| CERTIFICATE OF DEATH | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) RUFUS BRIGGS | | | | 2. DATE AND HOUR OF DEATH 12-13-66 7:45 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 915 CHERRY HILL ROAD | | | |
| 5. SEX M | 6. RACE N | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 7-5-77 | 9. AGE (In years, lost birth day) 89 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Sommerton, S.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME WEBB BRIGGS | | | | 14. MOTHER'S MAIDEN NAME ANNIE SERAN | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 213-34-3801 | | 17. INFORMANT Mrs. Maggie Briggs | | ADDRESS 915 Cherry Hill Rd. | |
| 18. 002, 1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) SYSTEMIC CANDIDIASIS | | | | CAUSE OF DEATH (A) DUE TO SYSTEMIC CANDIDIASIS | | INTERVAL BETWEEN ONSET AND DEATH 1 WEEK | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO TUBERCULOSIS | | 2 MONTHS | |
| (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypertension & ASVD | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/1 19 66 to 12/13 19 66 , that (I) (we) lost saw the deceased alive on 12/13 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE S. Nishkin | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 12/13/66 | |
| 23C. PHYSICIAN'S NAME (Type) S. Nishkin | | 23D. ADDRESS SHH | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12-18-66 | | 24C. NAME OF CEMETERY or CREMATORY Elizabeth Cem | | 24D. LOCATION (City, town, or county) (State) Manning S.C. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 15 1966 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Morton E. Dyett F.F.I. | | ADDRESS 1701 Laurens St. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12540 | |
|---|------------------|---|------------------------------|--|--|
| BIRTH NO. 66 12540 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) | | Donald Stevenson (Stephens) | | 2. DATE AND HOUR OF DEATH 12-12-66 5:00 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital | | (If not in hospital or institution, give street address or location) | | A. STATE Maryland | |
| | | | | B. COUNTY | |
| | | | | C. CITY OR TOWN (If outside city limits, give RURAL and give township) Baltimore, 15-02 | |
| | | | | D. STREET ADDRESS (If rural, give location) 1704 Lorman Street | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH 7-3-1918 | 9. AGE (In years lost birthday) 48 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY MARRIED | | 11. BIRTHPLACE (State or foreign country) Accoromac, Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME unk. | | 14. MOTHER'S MAIDEN NAME unk. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 212-14-2909 | | 17. INFORMANT Mrs. Myrtle Stephens | |
| | | | | ADDRESS 1617 N. Payson St | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Pneumonia Septicemia Anemia | | | | INTERVAL BETWEEN ONSET AND DEATH One day | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from December 12, 19 66 to December 12, 19 66 that (I) (we) last saw the deceased alive on December 12, 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Ata Amini, M.D. | | | | 23B. DATE SIGNED 12-12-66 | |
| 23C. PHYSICIAN'S NAME (Type) Ata Amini, M.D. | | | | 23D. ADDRESS 1514 Division Street Balto., Maryland | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-16-66 | | 24C. NAME OF CEMETERY or CREMATORY Balto. National Cem. Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 15 1966 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Morton & Dyett F.H. | |
| | | | | ADDRESS 1701 Laurens St | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12541 | |
|---|---------|--|---|--|------------------------------|
| BIRTH NO. 66 12541 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| (Type or Print) | | Junius Street | | 12-11-66 10:10 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| 00 1431 N. Ellwood Ave. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Maryland 8-03 | |
| | | D. STREET ADDRESS (If rural, give location) | | 1431 N. Ellwood Ave. | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | 10. CITIZEN OF WHAT COUNTRY? |
| Male | Negro | Widowed | 4-2-1885 | 81 | U.S.A. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? | |
| Farmer | | Self | Nottaway Co., Va. | U.S.A. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| UNKNOWN | | UNKNOWN | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| NO | | 230-52-0719A | Mrs. Florence Stokes 1431 N. Ellwood Ave. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 331X I | | (A) CRACKED - Vascular Accident | | 1 wk. | |
| ANTECEDENT CAUSES | | (B) Arteriosclerosis | | ? | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/6 1965 to 12/14/66 (APX) that (I) (we) last saw the deceased alive on 12/10 (APX) 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE J. Preston Grant | | | | 23B. DATE SIGNED 12/15/66 | |
| 23C. PHYSICIAN'S NAME (Type) J. Preston Grant | | | | 23D. ADDRESS 601 N. Carrollton Ave. Balto., Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Removal | | 12-14-66 | | Hickrock Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| DEC 15 1966 | | R. E. E. Taylor | | Randolph Collick 2431 E. Oliver St. | |

1914

Maryland
Baltimore

W. M. Ellwood, Jr.

W. M. Ellwood, Jr.

4-2-1888

Widowed

Male

Northway Co., Va.

Self

Former

Unknown

Unknown

no

1914

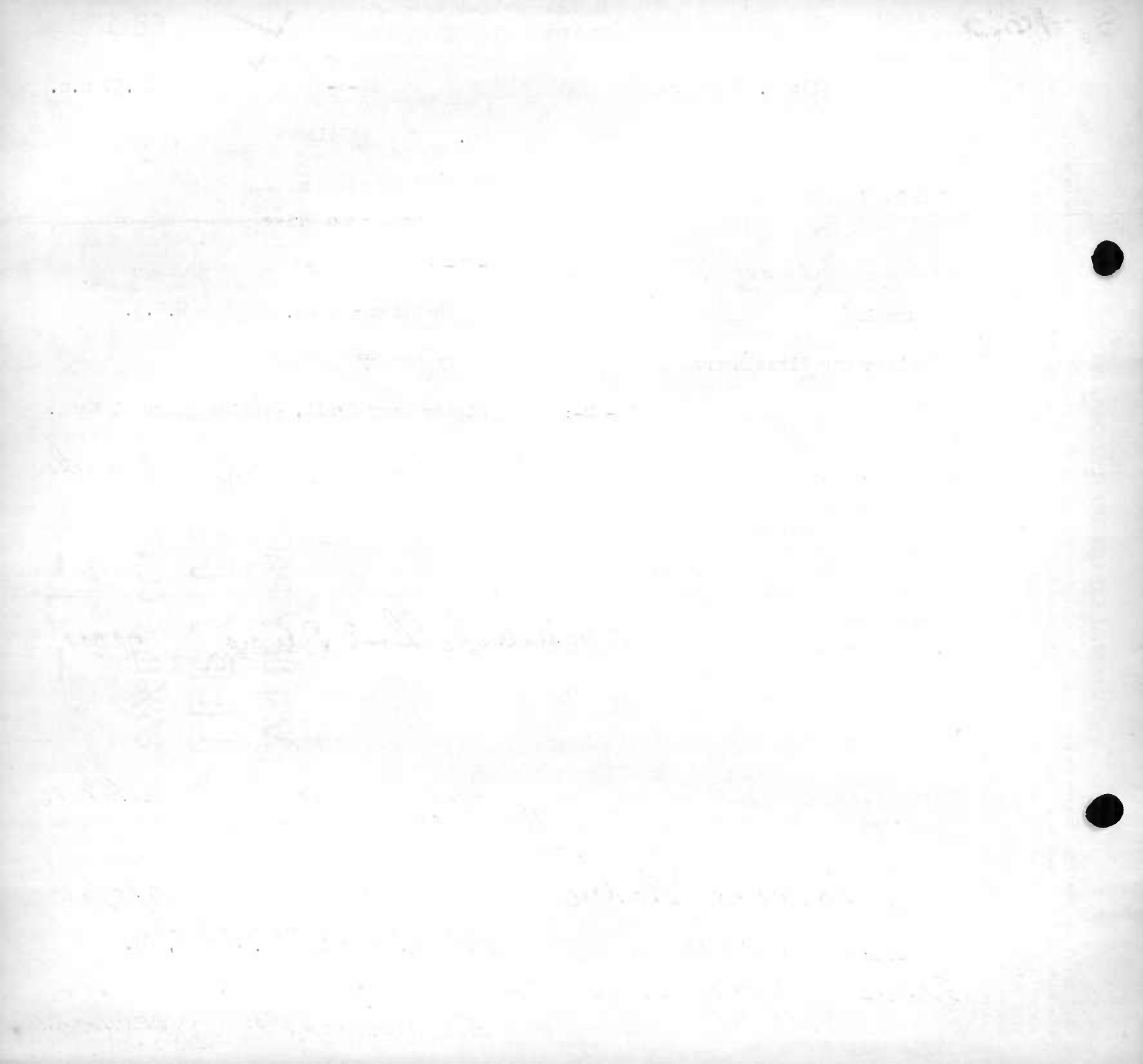
W. M. Ellwood, Jr.

W. M. Ellwood, Jr.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|------------------|---|---|
| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. <u>66 12542</u> | |
| BIRTH NO. <u>66 12542</u> | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>Ella E. Sheppard</u> | | <u>12-9-66</u> <u>11.59 a.m.</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Jenkins Memorial Hospital</u> | | A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>8706 Loch Bend Drive</u> | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>W</u> | 8. DATE OF BIRTH <u>9-21-86</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) <u>80</u> |
| 11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Christopher Fitzsimmons</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Murphy</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>212-30-1263</u> | |
| 17. INFORMANT <u>Sister Mary Cyril, Jenkins Memorial Hosp.</u> | | ADDRESS | |
| 18. <u>491X</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) <u>Pneumo pneumonia</u> (B) <u>3 weeks</u> (C) <u>INTERVAL BETWEEN ONSET AND DEATH</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Anterior lobe of Heart Decayed.</u> | | years. | |
| 19A. DATE OF OPERATION <u>12/13/66</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) <u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (H) (this hospital) attended the deceased from <u>12/13/66</u> <u>1966</u> to <u>12/13/66</u> <u>1966</u> and that (H) (we) last saw the deceased alive on <u>12/13/66</u> <u>1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <u>J. Raymond Gladue</u> M.D. | | 23B. DATE SIGNED <u>12/9/66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>J. Raymond Gladue</u> | | 23D. ADDRESS <u>Jenkins Memorial Hospital</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>12/13/66</u> | |
| 24C. NAME OF CEMETERY or CREMATORY <u>LOUDON PARK</u> | | 24D. LOCATION (City, town, or county) (State) <u>BAKTO. MD</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 15 1966</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Jackson</u> | |
| 25C. FUNERAL DIRECTOR <u>E.S. MACNABB</u> | | ADDRESS <u>301 FREDERICK RD</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|--|-------------------------|---|------------------------------------|---|---|
| BIRTH NO. 66 12543 | | CERTIFICATE OF DEATH | | 66 12543 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Joseph Dennis Boyle</i> | | 2. DATE AND HOUR OF DEATH <i>Dec 12, 1966</i> <i>620 P.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY FREDERICK Co. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) EMMITSBURG <i>60-00</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL <i>33</i> BALTIMORE, MD 21205 | | D. STREET ADDRESS (If rural, give location) | | | |
| 5. SEX <i>Male</i> | 6. RACE <i>White</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married | 8. DATE OF BIRTH 8-21-46 | 9. AGE (In years last birthday) <i>20</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) WAYNESBORO, PA. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME JOSEPH B. BOYLE | | 14. MOTHER'S MAIDEN NAME MARIAN HUMERICK | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Joseph B. Boyle, Emmitsburg, Md. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 081.0 I | | CAUSE OF DEATH (A) <i>Respiratory Insufficiency</i> DUE TO (B) <i>Poliomyelitis - old</i> DUE TO (C) <i>Scoliosis - Severe multiple</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>14 years</i> <i>4 yrs.</i> | |
| 19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION <i>12-6-66</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Scoliosis</i> | | 20A. AUTOPSY? (Yes or No) <i>No</i> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from <i>December 12, 1966</i> to <i>December 12, 1966</i> , that (I) (we) last saw the deceased alive on <i>December 12, 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <i>Gerald Finerman</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>12-12-66</i> | |
| 23C. PHYSICIAN'S NAME (Type) GERALD FINERMAN | | 23D. ADDRESS M.D. <i>Johns Hopkins Hospital Maryland</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Dec. 15, 1966 | | 24C. NAME of CEMETERY or CREMATORY St. Joseph's Catholic | |
| 24D. LOCATION Emmitsburg, Frederick Co. Md. | | 25A. DATE REC'D BY HEALTH DEPT. DEC 15 1966 | | 25B. NAME OF REGISTRAR <i>R. E. Taylor</i> | |
| 25C. FUNERAL DIRECTOR <i>Clarence E. Wilson</i> | | 25D. ADDRESS Emmitsburg, Md. | | | |

WEST BORD, IN

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|-------------------------|---|------------------------------------|---|----------------------------|--|-----------------------------|
| BIRTH NO. 66 12544 | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 66 12544 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) SADIE TURNER | | | | 2. DATE AND HOUR OF DEATH 12-13-66 7 ⁴⁵ P M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SOUTH BALTIMORE GENERAL HOSPITAL 43 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 23-01 D. STREET ADDRESS (If rural, give location) 112 WEST CLEMENT STREET | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) DIVORCED | 8. DATE OF BIRTH 3-20-01 | 9. AGE (In years last birthday) 65 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME HARRY W. ROTTEN | | | | 14. MOTHER'S MAIDEN NAME EMMA | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Family - Same | | ADDRESS | |
| 18. 581.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) Bleeding esophageal varices DUE TO (B) Cirrhosis of liver DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 2 days unknown | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 12-13-66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED GI bleeding | | 20A. AUTOPSY? (Yes or No) no | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12-11-1966 to 12-13-1966 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12-13-1966 and that <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE David M. Lanphear | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-14-66 | |
| 23C. PHYSICIAN'S NAME (Type) David M. Lanphear | | | | 23D. ADDRESS SOUTH BALTIMORE GENERAL HOSPITAL 1213 Light Street, Balto., Md. 21230 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 12/17/66 | | 24C. NAME OF CEMETERY OR CREMATORY Spring Hill | | 24D. LOCATION (City, town, or county) (State) EASTON, Md | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 15 1966 | | 25B. NAME OF REGISTRAR Robert E. Farley | | 25C. FUNERAL DIRECTOR Baltimore McClellan | | ADDRESS | |

15-12-66

15-12-66

15-12-66

15-12-66

15-12-66

Bleeding esophageal varices 2 days

Cirrhosis of liver

No

GI bleeding

15-12-66

(6)

15-12-66

15-12-66

15-12-66

15-12-66

15-12-66

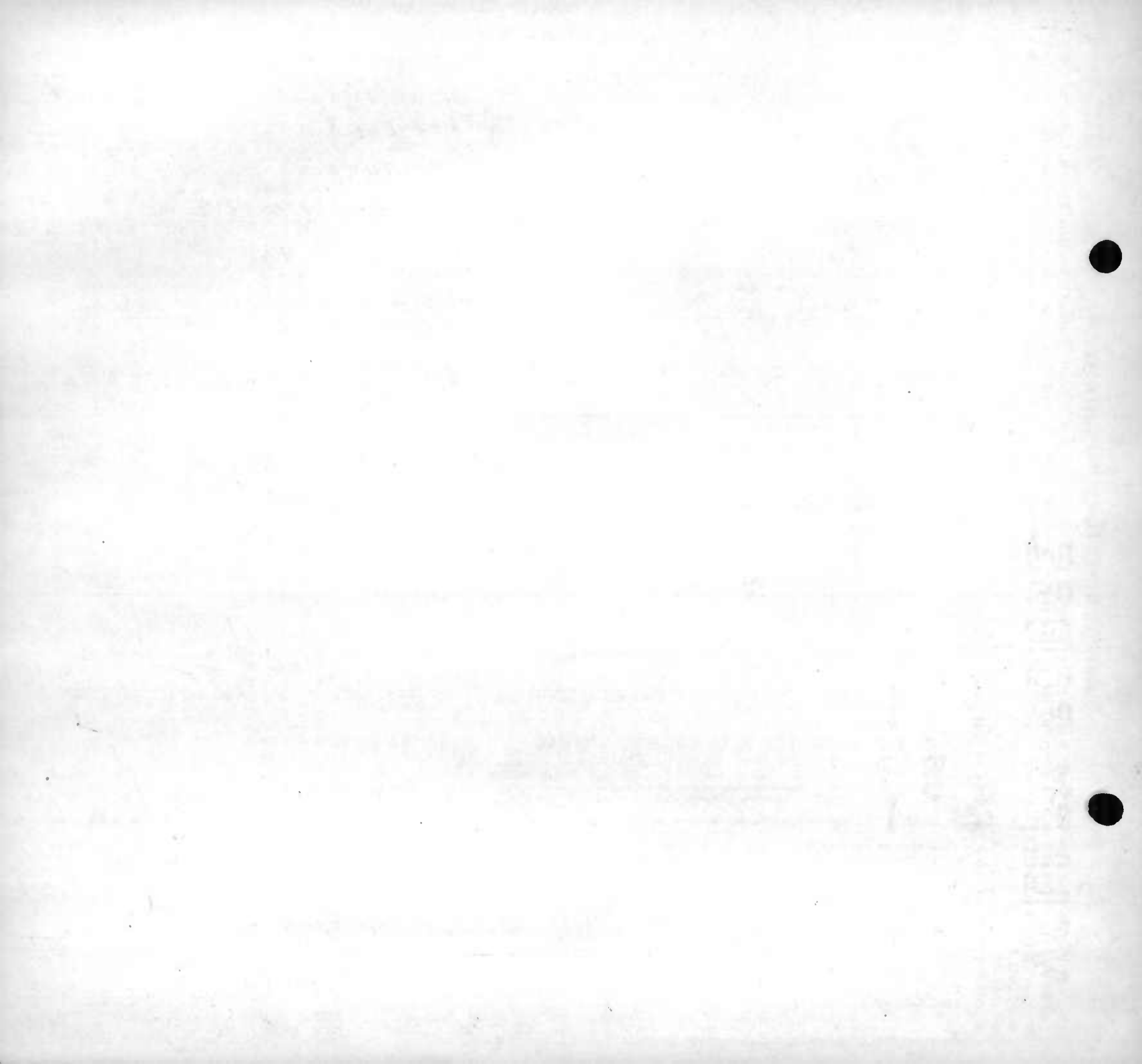
15-12-66

Barry M. Langford

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 12545</u> | |
|--|-------------------------|--|---|--|---|
| BIRTH NO. <u>66 12545</u> | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>EVELYN LOUISE STOKES</u> | | | 2. DATE AND HOUR OF DEATH <u>12/12/66</u> <u>2:25 P.</u> M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>FRANKLIN SQUARE HOSPITAL</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>808 E. NORTH AVE.</u> | | |
| 5. SEX <u>F</u> | 6. RACE <u>WHITE</u> | 7. <u>MARRIED</u> , NEVER MARRIED <u>WIDOWED</u> , DIVORCED (specify) | 8. DATE OF BIRTH <u>6/6/1890</u> | 9. AGE (In years last birthday) <u>76</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | 13. FATHER'S NAME <u>?</u> | | |
| 14. MOTHER'S MAIDEN NAME <u>?</u> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>?</u> | | |
| 16. SOCIAL SECURITY NO. <u>?</u> | | | 17. INFORMANT <u>MRS. PHYLLIS GASKINS</u> (DAUGHTER) ADDRESS <u>221 GRIMESLAND NORTH CAROLINA</u> | | |
| 18. <u>023X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>BRONCHOPNEUMONIA LEFT LOWER LOBBE</u> <u>ASCVD; SYPHILIS (?)</u> | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | INTERVAL BETWEEN ONSET AND DEATH <u>LEFT</u> | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>YES</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. HOW DID INJURY OCCUR? | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>11/27</u> 19 <u>66</u> to <u>12/12</u> 19 <u>66</u> . that (I) (we) lost saw the deceased alive on <u>12/12</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Thomas A. Alvero</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED <u>12/12/66</u> | | |
| 23C. PHYSICIAN'S NAME (Type) <u>TOMAS A. ALVERO</u> | | | 23D. ADDRESS M.D. <u>FRANKLIN SQUARE HOSPITAL</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12-16-66</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Greenwood, North Carolina</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 15 1966</u> | | | |
| 25B. NAME OF REGISTRAR <u>W. Earl Brooks Jr.</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>127 Howard St. Baltimore, Md.</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 12546</u> | |
|---|-------------------------|---|---|--|---|
| BIRTH NO. <u>66 12546</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>James M. Hines</u> | | 2. DATE AND HOUR OF DEATH <u>12/15/66</u> <u>6:30</u> <u>A</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>14 E. Eager Street</u> <u>Baltimore, Maryland 21202</u> | | A. STATE <u>Maryland</u> B. COUNTY _____ C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore 21202</u> D. STREET ADDRESS (If rural, give location) <u>14 E. Eager St.</u> | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED <u>Married</u> | 8. DATE OF BIRTH <u>Feb. 6, 1899</u> | 9. AGE (In years last birthday) <u>67</u> Years | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief Clerk. Eng. Off.</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>U. S. Lines</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Hines</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Holt</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes W.W. One</u> | | | |
| 16. SOCIAL SECURITY NO. <u>212-07-4324</u> | | 17. INFORMANT <u>14 E. Eager Street</u> <u>Mary R. Hines, Baltimore 2, Maryland</u> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerotic Cardiovascular Disease</u> | | CAUSE OF DEATH (A) DUE TO <u>Arteriosclerotic Cardiovascular Disease</u> (B) DUE TO _____ (C) DUE TO _____ | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>19 53</u> to <u>12/15/66</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10/4</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Thomas L. Worsley</u> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>12/15/66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Thomas L. Worsley, M.D.</u> | | 23D. ADDRESS <u>6505 York Rd., Baltimore, Maryland</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>Dec. 17, 1966</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Moreland Memorial Park</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 15 1966</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Tolson</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>Wm. Cook-Brooks, Inc., 1217 St. Paul St. Baltimore 2, Maryland</u> | |

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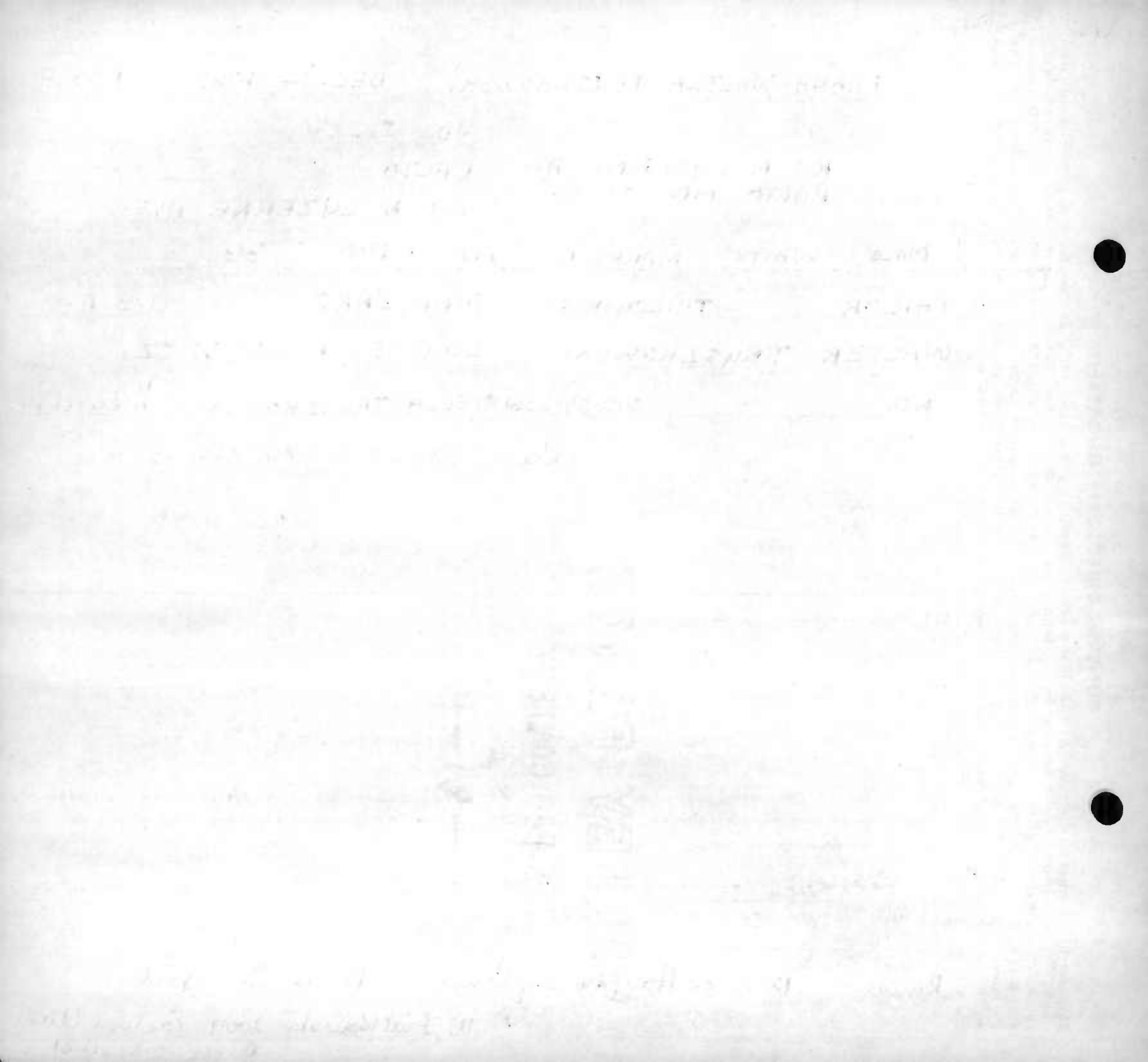
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 12547 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12547 | |
|--|-------------------------|---|--|---|--|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) FRANK WALTER TRUSZKOWSKI | | | | 2. DATE AND HOUR OF DEATH DEC. 14, 1966 1:00 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 00 | | (If not in hospital or institution, give street address or location) 109 N. LUZERNE AVE. BALTO. MD. 21224 | | A. STATE MD. 21224 | | B. COUNTY | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. 6-02 | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 109 N. LUZERNE AVE. | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | | 8. DATE OF BIRTH APRIL 1, 1900 | | 9. AGE (In years last birthday) 66 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAILOR | | 10B. KIND OF BUSINESS OR INDUSTRY TAILORING | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME WALTER TRUSZKOWSKI | | | | 14. MOTHER'S MAIDEN NAME LOUISE BLUSIEWICZ | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO. | | 16. SOCIAL SECURITY NO. 212-07-6361 | | 17. INFORMANT STELLA TRUSZKOWSKI | | ADDRESS 109 N. LUZERNE | |
| 18. 177X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CA of PROSTATE METASTASIS | | | | (A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO | | | |
| | | | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1960 19 to Dec 14 19 66 , that (I) (we) last saw the deceased alive on Dec 14 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Andrew Lemischka M.D. | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED December 14-66 | |
| 23C. PHYSICIAN'S NAME (Type) ANDREW LEMISCHKA | | 23D. ADDRESS M.D. 2608 E. BALTIMORE ST. BALTO. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-17-66 | | 24C. NAME OF CEMETERY or CREMATORY Holy Rosary Cem. | | 24D. LOCATION (City, town, or county) (State) Balto. Co. MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 15 1966 | | 25B. NAME OF REGISTRAR Robert E. Taylor, MD | | 25C. FUNERAL DIRECTOR W. Fialkowski | | ADDRESS 2007 Eastern Ave. Balto., MD. 21201 | |



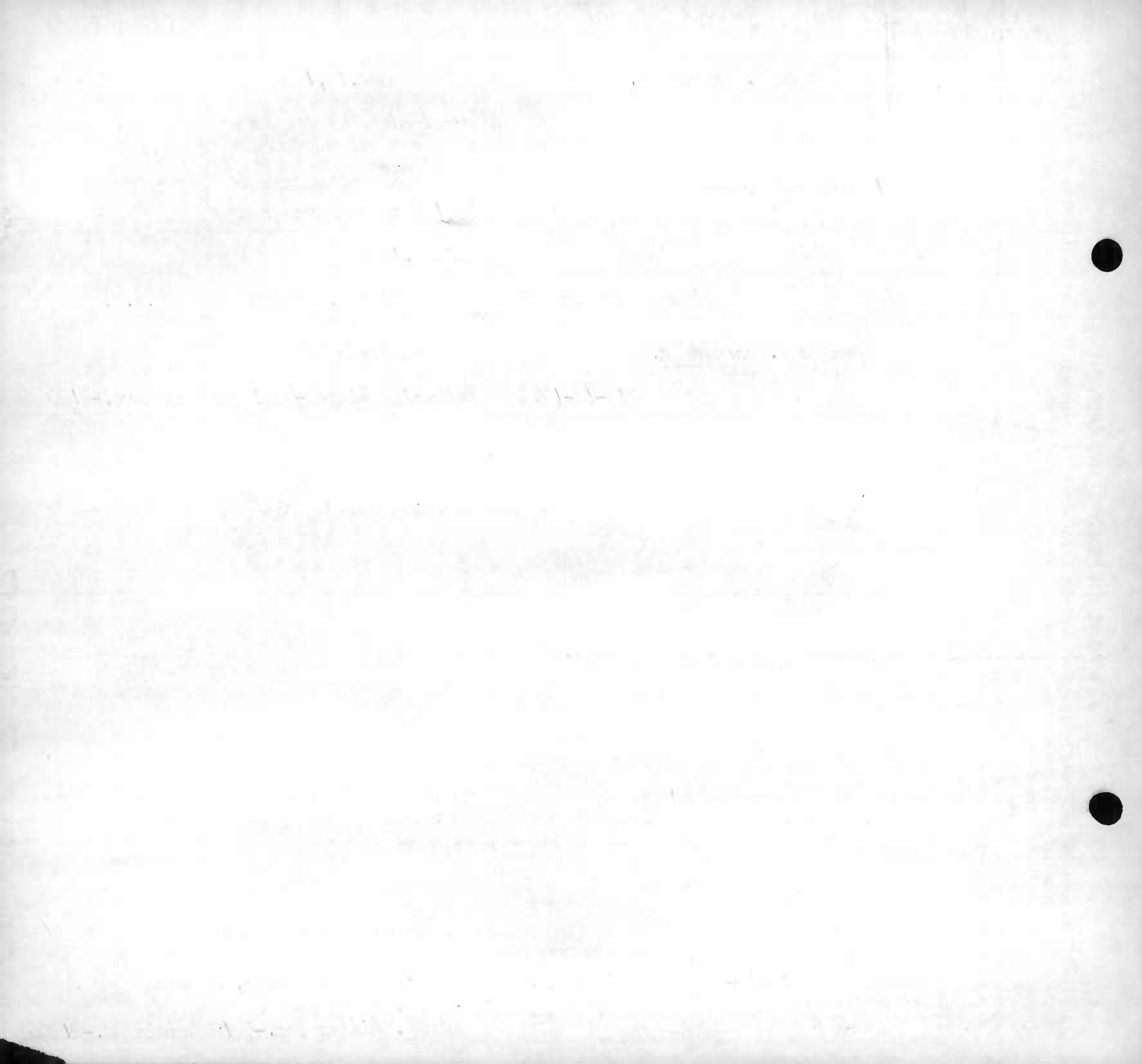
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12548 | |
|--|---------------------------|---|---|--|---|
| BIRTH NO. 66 12548 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) <i>A</i> Bessie White | | | 2. DATE AND HOUR OF DEATH December 12, 1966 3:40 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 00 1844 W. Fayette Street Baltimore, Maryland 21223 | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1844 W. Fayette Street | | |
| 5. SEX Female | 6. RACE Colored | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH June 20, 1892 | 9. AGE (In years last birthday) 74 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife | | | 11. BIRTHPLACE (State or foreign country) Towson, Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Amenial Mack | | | 14. MOTHER'S MAIDEN NAME Elizah Cittis | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Sarah Myers ADDRESS 1844 W. Fayette Street |
| 18. I 70X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Carcinoma of left breast DUE TO (B) about one year DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from none 1965 to Dec 8 1966, that (I) (we) last saw the deceased alive on Dec 8 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Harry Glassman | | | | 23B. DATE SIGNED Dec 14 - 66 | |
| 23C. PHYSICIAN'S NAME (Type) HARRY GLASSMAN | | 23D. ADDRESS 712 W. Fayette St Baltimore Md | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-15-66 | | 24C. NAME OF CEMETERY or CREMATORY Gulf Chapel Cemetery | |
| 24D. LOCATION Cockeysville, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. DEC 15 1966 | | | |
| 25B. NAME OF REGISTRAR Robert E. Farley | | 25C. FUNERAL DIRECTOR Arlington S. Phillips | | | |
| 25D. ADDRESS 1727 N. Monroe Street | | | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12549 | |
|---|-------------------------|--|--|--|---|
| BIRTH NO. 66 12549 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Charles F. Arnold Jr.</i> | | 2. DATE AND HOUR OF DEATH <i>Dec. 10, 1966</i> 4 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>4301 Parkmont Avenue</i> | | A. STATE <i>Maryland</i> B. COUNTY | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> 26-01 | | | |
| | | D. STREET ADDRESS (If rural, give location) <i>4301 Parkmont Avenue</i> | | | |
| 5. SEX <i>Male</i> | 6. RACE <i>White</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Single</i> | 8. DATE OF BIRTH <i>April 8, 1900</i> | 9. AGE (In years last birthday) <i>66</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Tailor</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Modern Manufacturing</i> | | 11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 13. FATHER'S NAME <i>Charles F. Arnold Sr.</i> | | | |
| 14. MOTHER'S MAIDEN NAME <i>Henrietta Diggs</i> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. <i>219-18-1543</i> | | 17. INFORMANT <i>Katherine Fitze</i> ADDRESS <i>4301 Parkmont Ave. -21206</i> | | | |
| 18. <i>443X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) <i>Cerebral Hemorrhage</i> DUE TO (B) <i>Hypertension - arteriosclerotic</i> DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i> <i>5 years</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Feb. 6</i> 19 <i>66</i> to <i>Dec. 10</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>Dec. 10</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Adam G. Swiss</i> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>Dec. 12, 1966</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Adam G. Swiss</i> | | 23D. ADDRESS <i>6132 Belair Road, Balto. Md. 21206</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12-14-66</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Baltimore, Cemetery</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 16 1966</i> | | | |
| 25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i> | | 25C. FUNERAL DIRECTOR <i>John C. Miller Inc. - 6415 Belair Rd. - 21206</i> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|---|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12550 | |
| BIRTH NO. 200 66 12550 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH 11 Dec 1966 8⁴² P.M. | |
| 1. NAME OF DECEASED (Type or Print) Mabel Virginia Lewis | | 8. COUNTY BALTIMORE | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balti. Co. | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MD. #21224 | | D. STREET ADDRESS (If rural, give location) 1401 E. HOMBERG AVENUE #21221 | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 9. AGE (In years last birthday) 59 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) MARYLAND | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME William Dorsey | | 14. MOTHER'S MAIDEN NAME Virginia | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT #21224 ADDRESS REC ORDS-BCH-4940 EASTERN AVENUE-BALTIMORE, MD. |
| 18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Uremia | | INTERVAL BETWEEN ONSET AND DEATH 6 days + | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) Kimmel-Steel-Wilson Kidney Disease 4 years (C) Diabetes Mellitus 4 yrs | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Myoclonic Seizure Disorder | | 6 days | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPTIC? (Yes or No) No | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 6 Dec 19 66 to 11 Dec 19 66 , that (I) (we) last saw the deceased alive on 11 Dec 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | |
| 23A. SIGNATURE Dudley A Raine Jr | | 23B. DATE SIGNED 11 Dec 1966 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Dudley A. Raine, Jr. | | 23D. ADDRESS #21224 BCH -4940 EASTERN AVENUE, BALTIMORE, M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 12-15-66 | 24C. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 16 1966 | 25B. NAME OF REGISTRAR Robert E. Taylor | 25C. FUNERAL DIRECTOR John C. Miller Inc-6415 Belair Road.-21206 | |

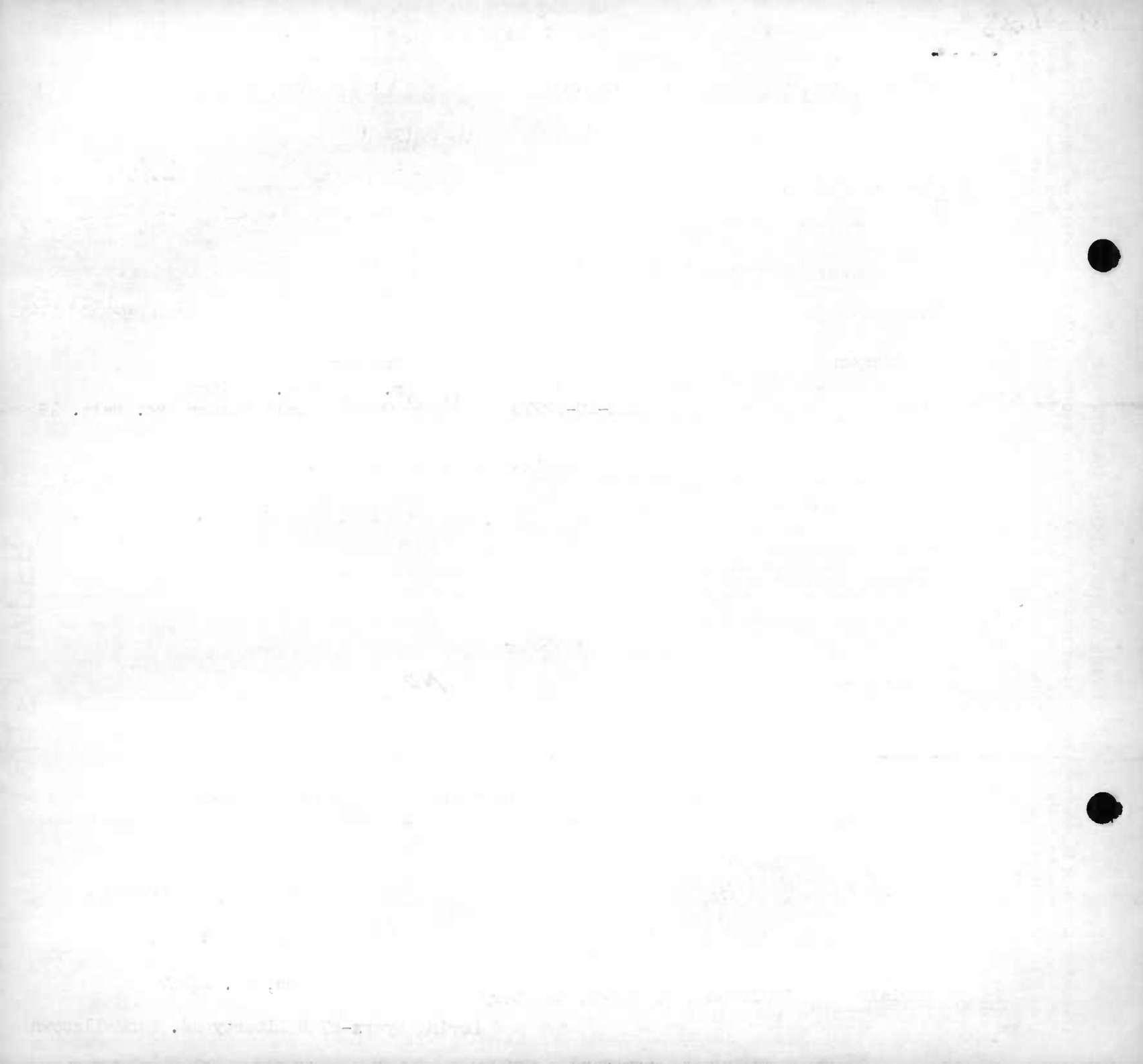
10/10/52

Barney A. Jones

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 12551</u> | |
|---|------------------|--|--------------------------------|--|---|
| BIRTH NO. <u>66 12551</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Milligan, Louisiana Hobbs</u> | | 2. DATE AND HOUR OF DEATH <u>December 14, 1966 3:00 A.M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>University Hospital</u> <u>38</u> | | A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>27-17</u> D. STREET ADDRESS (If rural, give location) <u>4812 Palmer Ave 21205</u> | | | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>married</u> | 8. DATE OF BIRTH <u>4/7/84</u> | 9. AGE (In years last birthday) <u>82</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>N.C.</u> | |
| 13. FATHER'S NAME <u>Unknown</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>United States</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>212-10-7277B</u> | | 17. INFORMANT <u>Mr. Albert J. Milligan</u> <u>Husband</u> ADDRESS <u>4812 Palmer Ave. Balt. 15</u> | |
| 18. <u>420.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) <u>Arteriosclerotic Cardiovas. Disease</u> DUE TO <u>one month</u> (B) <u>Myocardial Infarction</u> DUE TO <u>one year ago</u> (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>none</u> | | | | | |
| 19A. DATE OF OPERATION <u>none</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Nov 15</u> 19 <u>66</u> to <u>Dec 14</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec 14</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Salman S. Agur</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED <u>12/14/66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Salman S. Agur</u> M.D. | | | | 23D. ADDRESS <u>University Harbor</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12/16/66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Woodlawn Cemetery</u> | |
| | | | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md. 21207</u> | |
| 25A. DATE RECEIVED BY HEALTH DEPT. <u>DEC 16 1966</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Faley, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>Loring Byers</u> ADDRESS <u>8728 Liberty Rd. Randallstown</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|---|------------------------------------|--|---|
| Mother's Case No #45-22-41 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. <u>66 12552</u> | |
| BIRTH NO. <u>66 12552</u> <u>66-25546</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED <u>Baby Boy Cator</u> <u>Suzzette E.</u> | | 2. DATE AND HOUR OF DEATH <u>Dec 2, 1966</u> <u>8:06 P.M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Baltimore City Hospitals</u> <u>4940 Eastern Ave.</u> <u>Baltimore, Maryland # 21224</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>2006 East Eager Street</u> <u>21213</u> | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>Negro</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Never Married</u> | 8. DATE OF BIRTH <u>12/2/66</u> | 9. AGE (In years lost birthday) <u>---</u> | If Under 1 Yr. Months: <u>1</u> Days: <u>50</u> If Under 24 Hrs. Min. <u>50</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Ronald Lee Cator</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Suzzette Walker</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Records: BCH 4940 Eastern Ave. Baltimore, MD.</u> | | | |
| 18. <u>77351</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) <u>ANEMIA - ? etiology - UNKNOWN</u> DUE TO (B) <u>RESPIRATORY DISTRESS</u> DUE TO (C) <u>PREMATURITY</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>approx 14</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>2 0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>0</u> | | 20A. AUTOPSY? (Yes or No) <u>YES</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>BIRTH 2 Dec 1966</u> to <u>4:10 Pm 2 Dec 1966</u> , that (I) (we) last saw the deceased alive on <u>2 Dec 1966</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Thomas Philpot</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>2 Dec 1966</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Thomas Philpot</u> | | 23D. ADDRESS <u>Baltimore City Hospitals</u> <u># 21224</u> <u>4940 Eastern Ave. Baltimore, Maryland</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u> | | 24B. DATE <u>12-5-66</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Baltimore City Hospitals</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | | 24E. ADDRESS <u>21224</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 16 1966</u> | | 25B. NAME OF REGISTRAR <u>R. E. Fisher, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>HOSPITAL DISPOSAL</u> | |

[Faint, mostly illegible handwriting in the upper section of the page]

[Faint handwriting, possibly a signature or name, in the middle-left section]

[Faint handwriting in the lower section, including what appears to be a date '1871' and a signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 12553</u> | |
|--|-------------------------|---|-----------------------------------|--|--|
| BIRTH NO. <u>66 12553</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Reeder, Richard</u> | | 2. DATE AND HOUR OF DEATH <u>12-14-66</u> <u>12:45P M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>39 Provident Hospital</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore,</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>16-01</u> D. STREET ADDRESS (If rural, give location) <u>1109 Mosher Street</u> | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>Negro</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Separated</u> | 8. DATE OF BIRTH <u>3-3-96</u> | 9. AGE (In years lost birthday) <u>70 yrs.</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME <u>Mary</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes</u> | | 16. SOCIAL SECURITY NO. <u>216-10-9635</u> | | 17. INFORMANT <u>Mrs. Alice Reeder 1138 N. Stricker St.</u> | |
| 18. <u>444X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) <u>Pulmonary Embolism</u> DUE TO (B) <u>Generalized arteriosclerosis</u> DUE TO (C) <u>(?) Epilepsy</u> <u>Hypertension</u> <u>Pulmonary Infarct</u> <u>Murder</u> | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>December 6,</u> 19 <u>66</u> to <u>December 14,</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>December 14,</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>George G. Nelson</u> M.D. | | | | 23B. DATE SIGNED <u>12-14-66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Javier,</u> | | 23D. ADDRESS <u>1514 Division Street Balto., Maryland</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12-19-66</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Baltimore National Cem. Baltimore, Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 16 1966</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Jackson</u> | | 25C. FUNERAL DIRECTOR <u>George G. Nelson 1348 N. Calhoun St.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. 66 12554 | | CERTIFICATE OF DEATH | | Registered No. 66 12554 | |
|--|-------------------------|---|---|--|---|---|---|-------------------------|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) Weston, Rosetta | | 2. DATE AND HOUR OF DEATH 12-14-66 7:45 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 28-41 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL 33 | | | | D. STREET ADDRESS (If rural, give location) 4802 WILVAN AVENUE 21207 | | | | | |
| 5. SEX FEMALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 10-22-97 | 9. AGE (In years lost birthday) 69 yrs. | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME DAN TURNER | | | | 14. MOTHER'S MAIDEN NAME ELIZABETH OWENS | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. 220306203 | | 17. INFORMANT ADDRESS Violet Jones 4802 Wilvan Avenue | | | | |
| 18. 431X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial infarction Thoracic aortic aneurysm | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-12-66 to 12-14-66 , that (I) (we) last saw the deceased alive on 12-14-66 and that in (my) (her) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE David S. Fedson | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-14-66 | | | |
| 23C. PHYSICIAN'S NAME (Type) DAVID S. FEDSON | | | | 23D. ADDRESS M.D. THE JOHNS HOPKINS HOSPITAL | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-19-66 | | 24C. NAME of CEMETERY or CREMATORY Baltimore National Cem. | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | |
| 25A. DATE RECEIVED BY HEALTH DEPT. DEC 19 1966 | | 25B. NAME OF REGISTRAR Robert E. Farley | | 25C. FUNERAL DIRECTOR ADDRESS George G. Kelson 1348 N. Calhoun St. | | | | | |

underlying cause of Aneurysm - Atherosclerosis, aortic
See letter in Bur. of Vital Statistics Don't file
from J. H. H. 9c

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

RILEY

PIEREMAN

2. DATE AND HOUR PRONOUNCED DEAD

December 14, 1966

8:36 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

31 Baltimore City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

Baltimore Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2846 Old North Point Road

5. SEX

male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

Feb. 25, 1893

9. AGE (In years
last birthday)

73

11. Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

George Piereman

14. MOTHER'S MAIDEN NAME

Johanna Wright

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Riley W. Adey 4 North Point Terrace

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Multiple Traumatic Injuries.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? Yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

Old North Point Road near Oak Avenue

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

12 14 '66 P

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Pedestrian struck by auto.

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/15/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12-17-1966

23C. NAME of CEMETERY or CREMATORY

Baltimore

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

DEC 16 1966

Robert E. Farkner

Lilly & Zeiler Inc. 1901-07 Eastern Ave.

9-2-9

WILLIAM LEONARD

ALICE

WILLIAM LEONARD

WILLIAM LEONARD

WILLIAM LEONARD

WILLIAM LEONARD

WILLIAM LEONARD

WILLIAM LEONARD

WILLIAM LEONARD

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12556 | |
|--|---|---|--|--|---|
| BIRTH NO. 66 12556 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) POLYD W. HUFFMAN | | 2. DATE AND HOUR OF DEATH December 14, 1966 10:45 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 40 Saint Agnes Hospital Caton & Wilkens Aves. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2554 Southdene Avenue # 30 | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH Jan. 14, 1908 | 9. AGE (In years last birthday) 58 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed | | 10B. KIND OF BUSINESS OR INDUSTRY Egg Candler | | 11. BIRTHPLACE (State or foreign country) Washington, Pennsylvania | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME David Huffman | | | |
| 14. MOTHER'S MAIDEN NAME Zula Sprinkler | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | |
| 16. SOCIAL SECURITY NO. 212-01-1202 | | 17. INFORMANT ADDRESS Mrs. Reaver Huffman 2554 Southdene Ave. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) arteriosclerotic Heart Disease DUE TO (B) acute myocardial infarction DUE TO (C) | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from July 1 1955 to Dec 14 1966 , that (I) (we) last saw the deceased alive on Sept 15 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above: (I) (We) (ard) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Donald W. Mintzer | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED Dec 15 1966 | |
| 23C. PHYSICIAN'S NAME (Type) Donald W. Mintzer | | 23D. ADDRESS M.D. 3009 Evergreen Ave., Baltimore, Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-17-1966 | | 24C. NAME of CEMETERY or CREMATORY Oak Lawn | |
| 24D. LOCATION Baltimore County, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. DEC 16 1966 | | | |
| 25B. NAME OF REGISTRAR R. E. F. F. F. | | 25C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901-07 Eastern Ave. | | | |

1961-62



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|--|--|---|--|---|--|
| 66 12557 | | CERTIFICATE OF DEATH | | 66 12557 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| | | FERDINAND IN ROCK | | DEC. 12, 1966 8 ⁰⁵ P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 48 Md GEN HOSP. BALTO., Md 21201 | | A. STATE MARYLAND B. COUNTY Balt. Co | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Upperco 53-00 | |
| 5. SEX M | | 6. RACE W | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | |
| 8. DATE OF BIRTH 01/01/79 | | 9. AGE (In years last birthday) 87 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | |
| 11. BIRTHPLACE (State or foreign country) GERMANY | | 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME HERMAN ROCK | |
| 14. MOTHER'S MAIDEN NAME UNKNOWN | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 215-10-0832 | |
| 17. INFORMANT Kenneth R Koskinen | | 18. CAUSE OF DEATH | | ADDRESS md ✓ | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) A. S. C. V. D. Congestive Heart Failure | | INTERVAL BETWEEN ONSET AND DEATH 10 yrs. 10 yrs. | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pneumonia | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/06 to 12/12 1966, that (I) (we) last saw the deceased alive on 12/12/66 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE Kenneth R Koskinen | | 23B. DATE SIGNED 12/12/66 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS Md GEN HOSP BALTO., Md 21201 | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/15/66 | | 24C. NAME OF CEMETERY or CREMATORY WESTERN | |
| 24D. LOCATION (City, town, or county) (State) BALTO. Md. | | 25A. DATE REC'D BY HEALTH DEPT. DEC 16 1966 | | 25B. NAME OF REGISTRAR Philip E. Jarbo | |
| 25C. FUNERAL DIRECTOR F.B. Wippert | | 25D. ADDRESS 1300 EUTAW PL. | | | |

PERMANENT WORK

DEC 12 1944

W. GEN. HOSP
BHTO, ind. size

BRAND
Epperson
BLACK ROCK RS.

W. MIDWAY

OLATED RS

RETIRED
HERMAN ROCK

GERMANY
UNKNOWN

W. 4

NO 22-23-24 1944

HERMAN ROCK

X

W. GEN. HOSP. BHTO, ind. size

12/12/44

12/12/44

1
M-216

66 12558

BALTIMORE CITY HEALTH DEPARTMENT

66 12558

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

| | | | | | | | |
|--|-------------------------|---|--|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) BOOKER T. McBRIDE | | | | 2. DATE AND HOUR PRONOUNCED DEAD December 12, 1966 4:00 P M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 39 Provident Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore D. STREET ADDRESS (If rural, give location) 635 Smithson Street | | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 1/5/66 | 9. AGE (In years last birthday) 42 | If Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10B. KIND OF BUSINESS OR INDUSTRY Self employed | | 11. BIRTHPLACE (State or foreign country) Hemingway S Carolina | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME Ben McBride | | | | 14. MOTHER'S MAIDEN NAME Hallie | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes W W 2 | | 16. SOCIAL SECURITY NO. 250-28-4309 | | 17. INFORMANT Mrs Mary Lou McBride 3829 Parksheights | | | |
| 18. 322.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Alcoholism. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB- UTING <input type="checkbox"/> CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE m. WORK AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Petty M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Petty ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/13/66 | | | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 12/19/66 | 23C. NAME of CEMETERY or CREMATORY National Cemetery | | 23D. LOCATION (City, town, or county) (State) Baltimore Md | | |
| 24A. DATE REC'D BY HEALTH DEPT. DEC 16 1966 | | 24B. NAME OF REGISTRAR Robert E. Talley, M.D. | | 24C. FUNERAL DIRECTOR Adolphus Halstead 1206 W North Ave | | | |

1524

PCE-BS-GRS

228

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. | |
|---|---------|--|---|--|--|
| 66 12559 | | | | 66 12559 | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | | 2. DATE AND HOUR PRONOUNCED DEAD | | |
| GLADYS LOVETT | | | December 10, 1966 5:55 P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | A. STATE Maryland | | |
| 33 Johns Hopkins Hospital | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore | | |
| | | | D. STREET ADDRESS (If rural, give location) 1755 N. Gay Street | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| Female | Colored | Single wife | | 39 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| Domestic | | | Baltimore Md | | U S A |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| William B Bassil | | | Grace | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | |
| no | | | 218-48-4881 | | |
| 17. INFORMANT | | | ADDRESS | | |
| Mrs Berneice Dent | | | 1821 Ensor St | | |
| 18. CAUSE OF DEATH | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | | | |
| (A) Stab Wound of Abdomen DUE TO | | | | | |
| (B) DUE TO | | | | | |
| (C) DUE TO | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | Home | | 1755 N. Gay Street | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | Was Stabbed | |
| 12 10 '66 | | | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| Rudiger Breitenecker, M.D. | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | 12/11/66 | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | | 23C. NAME of CEMETERY or CREMATORY | |
| Burial | | 12/16/66 | | Mt Calvary Cemetery | |
| | | | | A A County Md | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | | 24C. FUNERAL DIRECTOR | |
| DEC 16 1966 | | Robert E. Farber, M.D. | | Adolphus Halstead | |
| | | | | 1206 W North Ave | |

FILED FOR

RECEIVED

no

William H. Smith

Grace

212-12-1231

Baltimore Md

Baltimore

Single

12/12/12 In Calvary Cemetery A A County Md

Johns Hopkins 1200 N North Ave

1
W-452

66 12560

BALTIMORE CITY HEALTH DEPARTMENT

66 12560

BIRTH NO. 66-20436

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

PATRICIA

WILLIAMS

2. DATE AND HOUR PRONOUNCED DEAD

December 13, 1966

11:10 A

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2803 W. North Avenue

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Infant

8. DATE OF BIRTH

9/23/66

9. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

3

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Infant

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Willie Williams

14. MOTHER'S MAIDEN NAME

Gloria Harvy

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Gloria Williams 2803 W North Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Interstitial Pneumonitis.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/13/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/17/66

23C. NAME of CEMETERY or CREMATORY

Arbutus Mem Park

23D. LOCATION

(City, town, or county)

Baltimore Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

DEC 16 1966

Robert E. Farley, M.D.

Adolphus Halstead 1206 W North Ave

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--------------|--|---|---|---|
| BIRTH NO. 66 12561 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12561 | |
| M.E. CASE NO. | | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) John William Franklin Murphy | | | 2. DATE AND HOUR OF DEATH Dec. 14, 1966 2:46 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Public Health Service Hospital Wyman Pk, Drive & 31st Street | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 9-01 D. STREET ADDRESS (If rural, give location) 509 Rosehill Terrace | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widower | 8. DATE OF BIRTH 1/25/91 | 9. AGE (In years lost birthday) 75 | 10. If Under 1 Yr. Months Days 11. If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Captain | | 10B. KIND OF BUSINESS OR INDUSTRY Seafarer | | 11. BIRTHPLACE (State or foreign country) Md. | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | 13. FATHER'S NAME John Spencer Murphy | | |
| 14. MOTHER'S MAIDEN NAME Mattie Bayne | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | |
| 16. SOCIAL SECURITY NO. 216-16-9605 | | | 17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Ms. | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Gram negative septicemia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Adenocarcinoma of colon OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | INTERVAL BETWEEN ONSET AND DEATH 18 hrs. Approx. 3 yrs. | | |
| 19A. DATE OF OPERATION 12/1/66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Small & large bowel obstruction | | 20A. AUTOPSY? (Yes or No) no | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Nov. 17 19 66 to Dec. 14 19 66, that (I) (we) last saw the deceased alive on Dec. 14 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Robert W. McCurdy M.D., Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED 12/14/66 | |
| 23C. PHYSICIAN'S NAME (Type) Robert W. Mc Curdy, Surgeon M.D. | | | | 23D. ADDRESS US PHS Hospital, Balto, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/17/66 | | 24C. NAME OF CEMETERY or CREMATORY Greenmount Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. | | | |
| 25B. NAME OF REGISTRAR John A. Moran, Inc. | | 25C. FUNERAL DIRECTOR ADDRESS 3000 E. Baltimore St | | | |

Robert W. McCurdy

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|------------------|--|------------------------------|---|--|
| BIRTH NO. M.E. CASE NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12562 | |
| 1. NAME OF DECEASED (Type or Print) | | Helen Frances Curren | | 2. DATE AND HOUR OF DEATH 13 Dec 1966 10:55 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | A. STATE Maryland | | B. COUNTY | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Baltimore | |
| | | D. STREET ADDRESS (If rural, give location) | | 6717 Graceland Avenue 21224 | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 12-29-18 | 9. AGE (In years last birthday) 47 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland, Oakland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME J.B. Moore | | 14. MOTHER'S MAIDEN NAME Daisy Moore | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 220-24-5214 | | 17. INFORMANT ADDRESS Records: BCH-4940 Eastern Avenue 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 491X I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Staph Pneumonia DUE TO (B) Aspiration Pneumonia DUE TO (C) Chronic Alcoholism | | INTERVAL BETWEEN ONSET AND DEATH 5-8 days 5-8 days Years | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 8 Dec 1966 to 13 Dec 1966, that (I) (we) last saw the deceased alive on 13 Dec 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Dudley A. Raine Jr. | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 13 Dec 1966 | |
| 23C. PHYSICIAN'S NAME (Type) Dudley A. Raine Jr. | | 23D. ADDRESS M.D. 4940 Eastern Avenue, Baltimore, Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/16/66 | | 24C. NAME OF CEMETERY or CREMATORY Short Run Cemetery | |
| 24D. LOCATION Oakland, Maryland | | 24E. (State) | | | |
| 25A. DATE RECD BY HEALTH DEPT. DEC 16 1966 | | 25B. NAME OF REGISTRAR John E. Taylor | | 25C. FUNERAL DIRECTOR John A. Moran, Inc. 3000 E. Baltimore St. | |
| 25D. ADDRESS | | | | | |

Handwritten text at the top of the page, possibly a header or title, which is mostly illegible due to fading.

2 1/2 lbs. Premium
Aspirin
Chronic Alcoholism

Yes

Dr. A. J. [illegible]

17 Dec 1911

cc - 13 Dec 1911

✓ 13 Dec 1911

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12563 | |
|---|---------------------|--|-------------------------------------|---|---|
| BIRTH NO. 66 12563 | | CERTIFICATE OF DEATH | | Registered No. 66 12563 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Helen C. Rosensteel</i> | | 2. DATE AND HOUR OF DEATH <i>Dec. 14, 1966</i> <i>2.30 p.m.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>00 3005 Frisby Street</i> | | A. STATE <i>Maryland</i> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>718 Homestead Street</i> | | | |
| 5. SEX <i>F</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Single</i> | 8. DATE OF BIRTH <i>3/3/1890</i> | 9. AGE (In years last birthday) <i>76</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Seamstress</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 13. FATHER'S NAME <i>Charles S. Rosensteel</i> | | 14. MOTHER'S MAIDEN NAME <i>Catherine Murphy</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>219-03-7787</i> | | 17. INFORMANT ADDRESS <i>Mr. Charles McGuin 3005 Frisby St.</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) <i>Carcinoma of the Esophagus</i> DUE TO (B) <i>Carcinoma of the Esophagus</i> DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH <i>2 1/2 years</i> <i>Several months</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>MAY 1964</i> to <i>2000 14 1966</i> , that (I) (we) lost saw the deceased alive on <i>2000 12 19 66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Edwin J. Berstock</i> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>2000 15 / 66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Edwin J. Berstock</i> | | 23D. ADDRESS <i>3500 N. Calvert Street #18</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12/17/66</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Moreland Memorial Park</i> | |
| 24D. LOCATION <i>Baltimore, Maryland</i> | | 24E. (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR <i>John A. Moran, Inc.</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>3000 E. Baltimore St.</i> | |

Government of the United States
Department of the Interior

May 12 1896
Bureau of Land Management
Washington, D.C.

66 12564

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66 12564

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

JANET A. ZOUCK

2. DATE AND HOUR PRONOUNCED DEAD

December 15, 1966 2:30 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

42 Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY Baltimore Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Pikesville 53-00

D. STREET ADDRESS (If rural, give location)

605 Upland Road

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Nov. 12, 1891

9. AGE (In years last birthday)

75

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

New York

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Edward L. Allen

14. MOTHER'S MAIDEN NAME

Elizabeth Kingsberry

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

None

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Robert Zouck 7804 Ruxwood Rd.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Multiple Traumatic Injuries.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Reisterstown Rd., S. of Slade Road

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

11

30

'66

P.m.

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Pedestrian struck by auto.

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/15/66

23A. BURIAL CREMATION, REMOVAL (Specify)

Removal

23B. DATE

12/17/1966

23C. NAME of CEMETERY or CREMATORY

Mt. Olivet Cemetery

23D. LOCATION

(City, town, or county)

(State)

Hanover, Pennsylvania

24A. DATE REC'D BY HEALTH DEPT.

DEC 16 1966

24B. NAME OF REGISTRAR

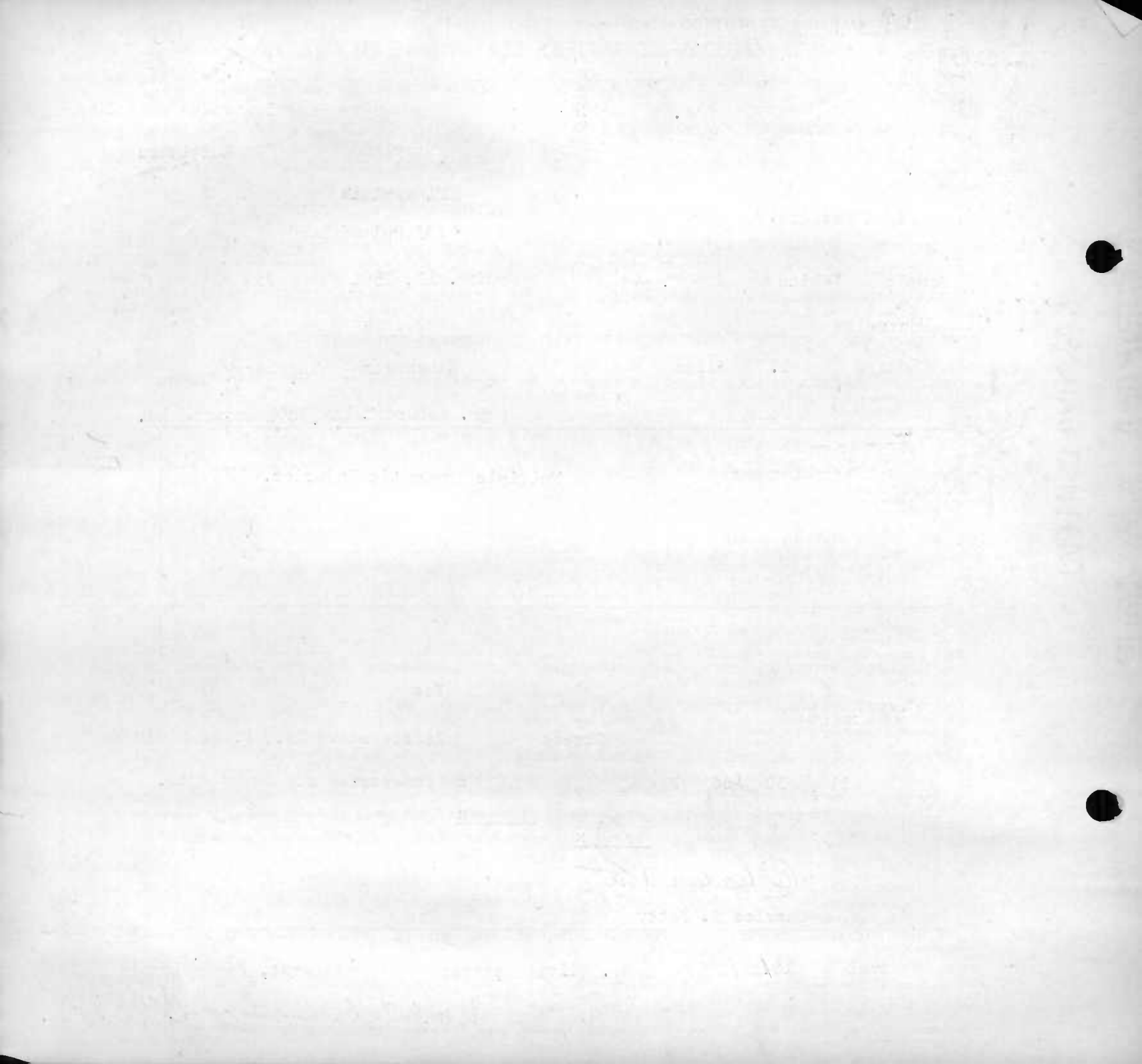
Robert E. Tarkenton

24C. FUNERAL DIRECTOR

Wm. J. Fisher & Sons Baltimore, Md.

ADDRESS

Baltimore, Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | Registered No. <u>66 12565</u> |
|--|--------------------------------|--|---|--|---|--------------------------------|
| BIRTH NO. <u>66 12565</u> | | CERTIFICATE OF DEATH | | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Vogt, Henry NMN</u> | | 2. DATE AND HOUR OF DEATH <u>10.30 Am. Dec 14, 1966</u> | | M. |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>The Union Memorial Hospital</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>27-48</u> D. STREET ADDRESS (If rural, give location) <u>1003 E. Belvedere Ave Apt. B</u> | | |
| 5. SEX <u>M</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u> | 8. DATE OF BIRTH <u>11/07/89</u> | 9. AGE (In years last birthday) <u>77</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Attorney</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore</u> | 12. CITIZEN OF WHAT COUNTRY? <u>American</u> | |
| 13. FATHER'S NAME <u>John P. Vogt</u> | | | 14. MOTHER'S MAIDEN NAME <u>Margaret Wieland</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u> | | 16. SOCIAL SECURITY NO. <u>213-03-9877</u> | | 17. INFORMANT <u>Mrs. Adelaide Weathersbee</u> ADDRESS <u>5832 Northwood Dr #12</u> | | |
| 18. CAUSE OF DEATH <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Congestive heart failure & myocardial ischemia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | |
| 19A. DATE OF OPERATION <u>Nov 23, 1966</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Nov 23, 1966</u> to <u>Dec 14, 1966</u> , that (I) (we) last saw the deceased alive on <u>10.30 Am. Dec 14, 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | |
| 23A. SIGNATURE <u>Sang Won Song</u> M.D. | | | | 23B. DATE SIGNED <u>Dec 14, 1966</u> | | |
| 23C. PHYSICIAN'S NAME (Type) <u>SANG WON SONG</u> | | 23D. ADDRESS M.D. <u>THE UNION MEMORIAL HOSPITAL</u> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | 24B. DATE <u>12/17/1966</u> | 24C. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u> | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 16 1966</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Fairley</u> | | 25C. FUNERAL DIRECTOR <u>Wm. J. Tichner</u> ADDRESS <u>Baltimore, Md.</u> | | |

100 E. Baltimore Ave. Bk 2

White House

Attorney General

John P. Mohr

MA

Call: 100 E. Baltimore Ave. Bk 2

100 E. Baltimore Ave. Bk 2

11/21/41

Galtimore

Margaret Wilson

Mrs. Adelaide Weatherhead

Confidential Source: T. J. [unclear]
[unclear]

Handwritten signature

100 E. Baltimore Ave. Bk 2

11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 12566 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12566 | |
|--|-------------------------|---|------------------------------------|---|---|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Williams, Walter H.</u> | | | | 2. DATE AND HOUR OF DEATH <u>12/11/66</u> <u>12 15</u> P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE <u>Baltimore City Hospitals</u> <u>31</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland #21224</u> | | | | A. STATE <u>Maryland</u> B. COUNTY <u>16-01</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>1010 N. Carrollton Ave. #21217</u> | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>Negro</u> | 7. MARRIED, NEVER MARRIED <u>WIDOWED, DIVORCED (specify)</u> <u>Separated</u> | 8. DATE OF BIRTH <u>6-12-30</u> | 9. AGE (In years lost birthday) <u>36</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>HOWARD (Deceased)</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Elaine Willie Ann</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>230-34-4700</u> | | 17. INFORMANT ADDRESS <u>RECORDS: BCH Baltimore, Md. #21224</u> | | | |
| 18. <u>465 X 17 002.2</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) <u>Pulmonary Embolus</u> DUE TO (B) <u>Pulmonary T.B.C. (inactive) 1960</u> DUE TO (C) <u>Chronic emphysema</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Pneumonia</u> | | | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>YES</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that <u>(H)</u> (this hospital) attended the deceased from <u>10/17</u> 19 <u>66</u> to <u>12/11</u> 19 <u>66</u> , that <u>(H)</u> <u>(we)</u> last saw the deceased alive on <u>12/11</u> 19 <u>66</u> and that in <u>(our)</u> <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. <u>(H)</u> <u>(We)</u> <u>(did)</u> <u>(did not)</u> view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Carl Winterstein</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED <u>12/11/66</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>Carl Winterstein</u> | | | | 23D. ADDRESS M.D. <u>4940 Eastern Avenue</u> <u>Baltimore, Md. #21224</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12/18/66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>South Boston</u> | | 24D. LOCATION (City, town, or county) (State) <u>South Boston Va</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 16 1966</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Sawyer</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>Charles A. Rice 661 W. 3rd St</u> | | | |

ON APPROVAL BY DR. BREITNECKER M.E.
ON FUNERAL DIRECTOR: IMPORTANT
RELEASED ON

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-----------------------|--|--|--|--|
| BIRTH NO. 66 12567 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12567 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) CELISE RIDEOUT | | 2. DATE AND HOUR OF DEATH Dec 10, 1966 5:50 P M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL | | A. STATE MARYLAND | | | |
| | | B. COUNTY | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location) 2231 N. CALVERT ST. | | | |
| 5. SEX FEMALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED | 8. DATE OF BIRTH 6-21-66 | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME RONALD GRIFFIN | | | 14. MOTHER'S MAIDEN NAME GWENDOLYN RIDEOUT | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 754.6T CAUSE OF DEATH (A) Myocardopathy DUE TO (B) CHD DUE TO (C) Bronchopneumonia INTERVAL BETWEEN ONSET AND DEATH 4 mo birth 3 days | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec 10 1966 to Dec 10 1966, that (I) (we) lost saw the deceased alive on Dec 10 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Jerold J. Yecies M.D. | | 23B. DATE SIGNED Dec 10, 1966 | | | |
| 23C. PHYSICIAN'S NAME (Type) JEROLD J. YECIES M.D. | | 23D. ADDRESS Johns Hopkins Hosp. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 12/15/66 | 24C. NAME of CEMETERY or CREMATORY Mt Auburn | 24D. LOCATION (City, town, or county) (State) Baltimore Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 16 1966 | | 25B. NAME OF REGISTRAR Robert E. Taylor | 25C. FUNERAL DIRECTOR ADDRESS Charles Rice 661 W. Barre St | | |

March 1952

W. J. ...
T. T. ...

March 1952

March 1952

March 1952
C#0
March 1952

March 1952

March 1952

March 1952

March 1952
March 1952

March 1952
March 1952

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | |
|---|--|--|--|---|---|---|--|--|--|--|--|-------------------------------------|--|--|
| BIRTH NO. 66 12568 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 66 12568 | | | | |
| 1. NAME OF DECEASED (Type or Print) CHARLES Rothhaupt | | | | | 2. DATE AND HOUR OF DEATH 12-15-66 9 AM | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY X | | | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Mercy Hospital | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | | | | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) 4402 CLAREWAY | | | | | | | | | |
| 5. SEX M | | 6. RACE W | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED, (specify) married | | 8. DATE OF BIRTH Oct 24 1898 | | 9. AGE (In years last birthday) 68 | | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | | 11. BIRTHPLACE (State or foreign country) Maryland | | | | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A | | | | | 13. FATHER'S NAME John Rothhaupt | | | | | 14. MOTHER'S MAIDEN NAME Volkmeyer | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | | 16. SOCIAL SECURITY NO. 817-01-4207 | | | | | 17. INFORMANT Dorothy Rothhaupt | | | | |
| 18. 002,11 | | | | | CAUSE OF DEATH Respiratory Arrest | | | | | ADDRESS 4402 Clareway | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES | | | | | (A) DUE TO | | | | | INTERVAL BETWEEN ONSET AND DEATH 10 yrs | | | | |
| (B) DUE TO Active Tuberculosis, LLL | | | | | (C) DUE TO Old Tuberculosis, Upper Lobes | | | | | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic Obstructive Airway Disease, Severe | | | | | | | | | |
| 19A. DATE OF OPERATION 12/14/66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Severe Respiratory Distress | | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | | (If in Baltimore City, give exact location) | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-14 19 66 to 12-15 19 66 , that (I) (we) last saw the deceased alive on 12-15 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 23A. SIGNATURE Michael A. Ellis | | | | | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> Intern <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/15/66 | | |
| 23C. PHYSICIAN'S NAME (Type) Michael A. Ellis | | | | | | | | | | 23D. ADDRESS Mercy Hospital Balto, Md. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 12-19-66 | | 24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery | | 24D. LOCATION (City, town, or county) (State) Taylor Ave Balto Md | | | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 16 1966 | | 25B. NAME OF REGISTRAR Robert E. Taylor, MD | | 25C. FUNERAL DIRECTOR Ho & Co 7200 Hayford Road | | ADDRESS | | | | | | | | |

My name is

John

Doyle
Resident of West
Active Tuberculosis, etc.
Old Tuberculosis, etc.

(From Chestnut Street Station, June)

12/14/66 Severe Respiratory Distress No

12-12

12-14

12-12

Michael A. Ellis

Michael A. Ellis

Mary Hospital, Baltimore, Md.

Number 18-H-6
to the 18-H-6
to the 18-H-6

66 12569

BALTIMORE CITY HEALTH DEPARTMENT

66 12569

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

PATRICIA E. BRUNO

2. DATE AND HOUR PRONOUNCED DEAD

December 14, 1966 1:00 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

31 Baltimore City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

1217 Cavendish Way

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

NOV 3, 1937

9. AGE (In years
last birthday)

19

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

WAITRESS

10B. KIND OF BUSINESS OR INDUSTRY

BRENTWOOD INN

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

ALVIN L. PERRY

14. MOTHER'S MAIDEN NAME

EVELYN D. MARTINO

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

823 FREDERICK AVE

18. E976X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Gunshot Wound of Head
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

apartment building

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

Apt. C. 1303 Anglesea Street

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
10 2 '66 6:00P

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Shot self.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Rudiger Breitenecker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/14/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

12-17-66

23C. NAME OF CEMETERY or CREMATORY

OAKLAWN CEMETERY

23D. LOCATION

EASTERN AVE

(City, town, or county)

BALTO MD

(State)

24A. DATE REC'D BY HEALTH DEPT.

DEC 16 1966

24B. NAME OF REGISTRAR

Robert E. Farkas

24C. FUNERAL DIRECTOR

LEO G. COOK

ADDRESS

7760 HARFORD ROAD

Baltimore

NOV 3 1937

MARRIED

WATNESS, Beatrice Ann Maryland

ALVIN L. PERRY

EVERETT D. MARTIN
843 FREDERICK

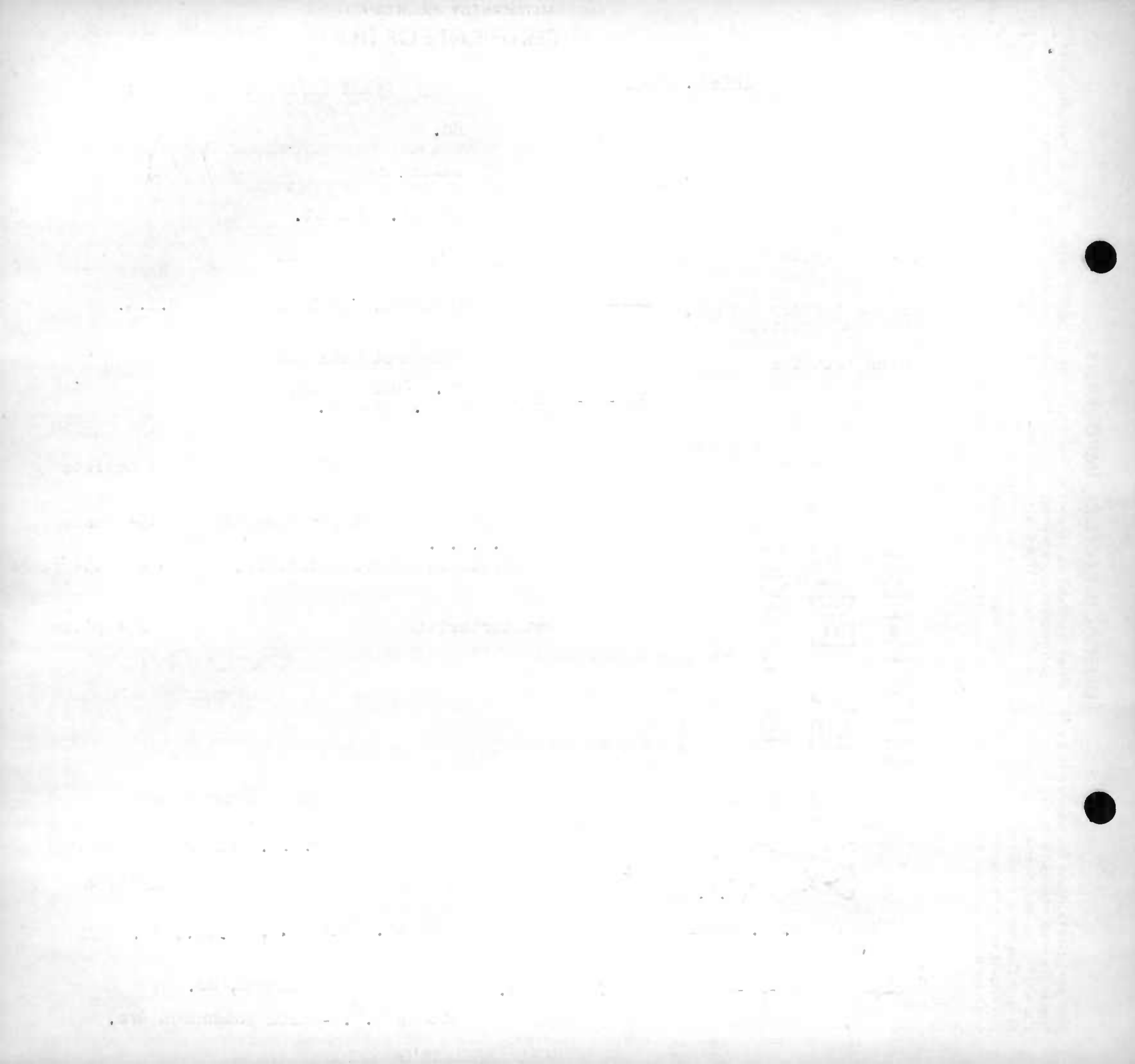
No

ORIGINAL
RECEIVED

Bureau 19-17-cc OAKMAN COUNTY EASTERN AVE. BUREAU
LEE G. COOK 3500 HARFORD ROAD

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12570 | |
|--|---------|--|------------------|--|--|
| BIRTH NO. 66 12570 | | CERTIFICATE OF DEATH | | Registered No. 66 12570 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Elsie E. Sipes | | 12/14/66 8:30 M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| 38 University Hospital | | Md. | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 923 St. Paul St. | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| Female | White | Widowed | 8/25/86 | 80 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| paper box factory worker, ---- | | | | Baltimore, Maryland | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| John Matthias | | Margaret Matthias | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 215-05-2791 A | | Mrs. Julia Matthias 923 S. Paca St. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshteno, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES | | (A) Myocardial infarction DUE TO | | Immediate | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | (B) Hypertensive arteriosclerotic C.V.R.D. DUE TO | | 15+ years | |
| | | (C) Generalized arteriosclerosis, moderate | | 15+ years | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Osteoarthritis | | 15+ years | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, lactory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (did not) attended the deceased from 19 50 to date of death 19 66 | | that (I) (did not) saw the deceased alive on December 13 19 66 and that in (my) (my) opinion death occurred on the date and hour and from the cause stated above. (I) (did not) view the body after death. | | D.O.A. University Hospital | |
| 23A. SIGNATURE (R.V. Rangle) | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 12/15/66 | |
| 23C. PHYSICIAN'S NAME (Type) R. V. Rangle | | 23D. ADDRESS 2938 St. Paul St., Balto., Md. 21218 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-17-66 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore Cem. | |
| | | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 16 1966 | | 25B. NAME OF REGISTRAR Robert E. Jarbo | | 25C. FUNERAL DIRECTOR ADDRESS Witzke F. - 4101 Edmondson Ave. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|--|---------------|--|--|--|--|
| BIRTH NO. | | 66 12571 | | 66 12571 | |
| CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | | 2. DATE AND HOUR OF DEATH | | |
| Mary Cosgrove | | | 12/15/66 5:00 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | A. STATE Md. | | |
| 4611 Marx Ave. | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore. | | |
| | | | D. STREET ADDRESS (If rural, give location) 4611 Marx Ave. | | |
| 5. SEX F. | 6. RACE W. | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH 7/13/80 | 9. AGE (In years last birthday) 86 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| Registered Nurse | | | Myersville, Pa. | | U.S.A. |
| 13. FATHER'S NAME William Cosgrove | | | 14. MOTHER'S MAIDEN NAME Bridget Harnon | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | | 16. SOCIAL SECURITY NO. 121051828A | | 17. INFORMANT Family Records |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 420.1 I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) DUE TO Cerebral Thrombosis (B) DUE TO Arteriosclerotic Heart Disease (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH 1 year |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cerebral Thrombosis | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from June 9 1965 to December 15 1966, that (I) last saw the deceased alive on December 14 1966 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Albert B Bradley | | | | 23B. DATE SIGNED 12/16/66 | |
| 23C. PHYSICIAN'S NAME (Type) Albert Bradley | | | | 23D. ADDRESS M.D. 4900 Belair Rd. Balto. Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/19/66 | | 24C. NAME of CEMETERY or CREMATORY St. Mary's Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State) Hanover Township, Pa. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 16 1966 | | 25B. NAME OF REGISTRAR J. E. Taylor | | 25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. | |

Robert H. Brown

Robert H. Brown

Mr. A. B. B. B.

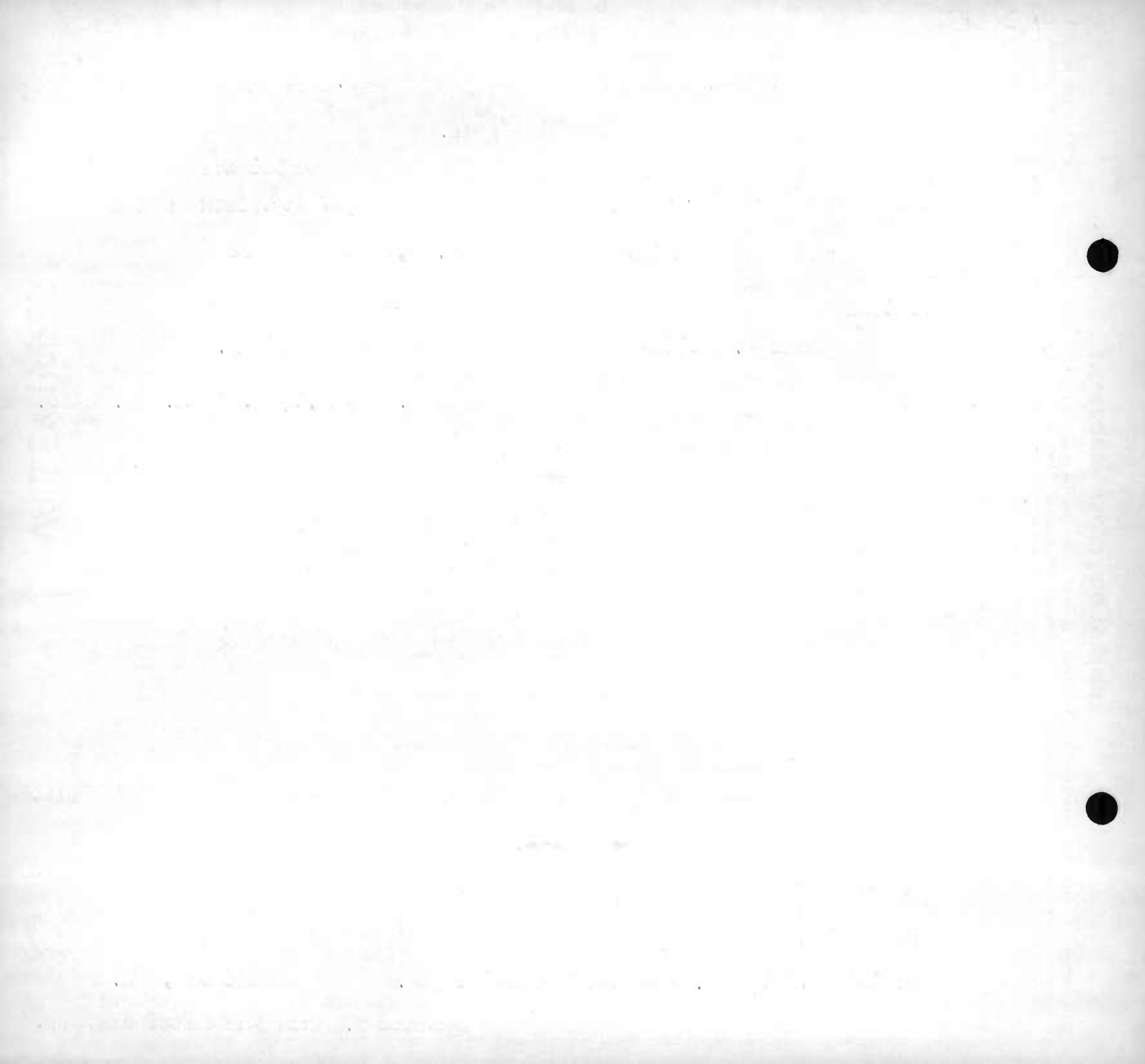
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Underdetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|------------------|---|---|
| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12572 | |
| BIRTH NO. 66 12572 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Capizzi, Carl | | 2. DATE AND HOUR OF DEATH 12/14/66 12:30 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital (If not in hospital or institution, give street address or location) | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore #13 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #13 D. STREET ADDRESS (If rural, give location) 3527 Lyndale Avenue | |
| 5. SEX XX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married | 8. DATE OF BIRTH 8/29/21 80 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY Paper Hanger | 9. AGE (In years last birthday) 45 86 |
| 11. BIRTHPLACE (State or foreign country) Italy | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME ? Capizzi | | 14. MOTHER'S MAIDEN NAME Cornelia Unknown | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Mrs. Carmela Capizzi | | ADDRESS (Same) | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 33/X I Cerebral arteriosclerosis Antecedent Causes: Cerebral Vascular Accident Bronchopneumonia | | INTERVAL BETWEEN ONSET AND DEATH ? 1 mo. 4 days. | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Urinary tract infection | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/10/66 19 to 12/14/66 19, that (I) (we) last saw the deceased alive on 12/14/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE C. H. Brown, III | | 23B. DATE SIGNED 12/14/66 | |
| 23C. PHYSICIAN'S NAME (Type) C. H. Brown, III | | 23D. ADDRESS The Johns Hopkins Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/17/66 | |
| 24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 16 1966 | | 25B. NAME OF REGISTRAR Robert E. ... | |
| 25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214 | | ADDRESS | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

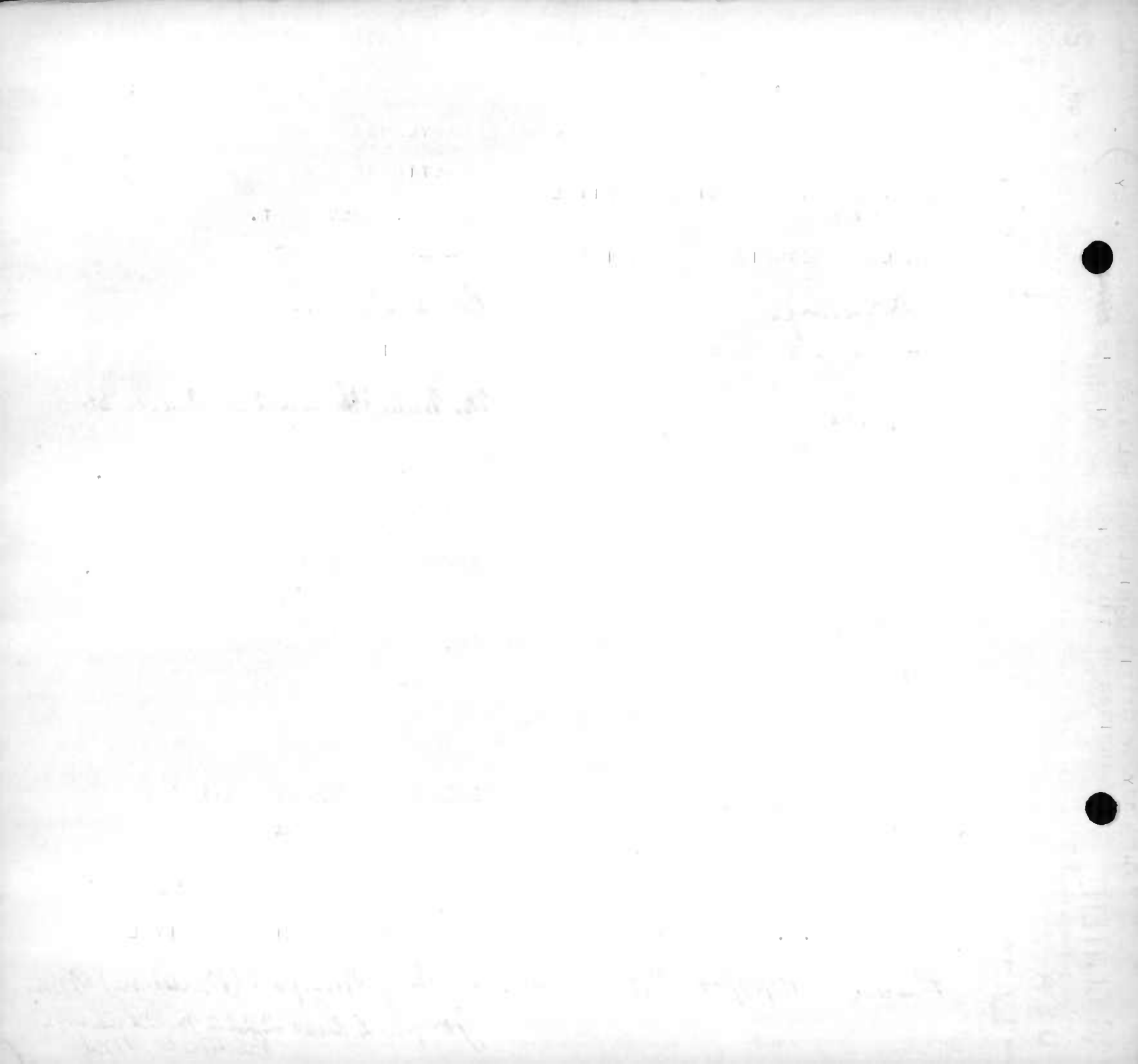
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. | |
|---|-------------------------|--|--|---|--|---|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | 66 12573 | |
| BIRTH NO. 66 12573 | | M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) <i>James Holman Chiles</i> | | | | | | 2. DATE AND HOUR OF DEATH <i>Dec. 14, 1966</i> <i>7:10 P.M.</i> | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>90 Pine Ridge Nursing Home</i> <i>4703 Hampnett Ave.</i> | | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY | | | | | |
| | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> <i>27-02</i> | | | | | |
| | | | | | | D. STREET ADDRESS (If rural, give location) <i>2901 Overland Avenue</i> | | | | | |
| 5. SEX <i>male</i> | 6. RACE <i>white</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i> | | 8. DATE OF BIRTH <i>Dec. 6, 1878</i> | | 9. AGE (In years last birthday) <i>88</i> | | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i> | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Virginia</i> | | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | |
| 13. FATHER'S NAME <i>James M. Chiles</i> | | | | | | 14. MOTHER'S MAIDEN NAME <i>Julia F.</i> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>James B. Lyons, 24 E. 25th. St. Balto. Md.</i> | | | ADDRESS | | |
| 18. <i>422.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) <i>Hypostatic pneumonia</i> <i>associated</i> (B) <i>Chronic myocarditis</i> DUE TO (C) <i>Generalized arteriosclerosis</i> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Malnutrition, senility</i> | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>March 3</i> 19 <i>64</i> to <i>Dec. 14</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>Dec. 14</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE <i>H. V. Harbold</i> M.D. | | | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED <i>Dec. 16, 1966</i> | | |
| 23C. PHYSICIAN'S NAME (Type) <i>H. V. HARBOLD</i> | | | | | | 23D. ADDRESS M.D. <i>4706 HARFORD Rd Baltimore Md</i> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12/17/66</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Moreland Memorial Cem.</i> | | | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR <i>DEC 16 1966 R. E. Johnson</i> | | | | 25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc Baltimore, Md.</i> | | | |
| ADDRESS | | | | | | | | | | | |



THE BODY OF MATTIE HAMEL WAS RELEASED AS NON-MED. BY DR. CORRIGAN OF THE MEDICAL FUNERAL DIRECTOR'S OFFICE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|------------------------------|---|--|---|--|
| BIRTH NO. 66 12574 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12574 | |
| M.E. CASE NO. | | | 1. NAME OF DECEASED (Type or Print) Haniel, Mattie | | |
| 2. DATE AND HOUR OF DEATH 12/14/66 16:35 P M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS HOSPITAL | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | |
| | | | O. STREET ADDRESS (If rural, give location) 216 N. CULVER ST. | | |
| 5. SEX FEMALE | 6. RACE NEGROID | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 5-8-28 | 9. AGE (In years last birthday) 38 | If Under 1 Yr. Months: Oays: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Blackstone, Va. | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME K QUARLES KNOX | | | 14. MOTHER'S MAIDEN NAME FANNIE LOVE | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS Mr. Willie Haniel 216 N. Culver St. | | |
| 18. 456X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Chronic glomerulonephritis 8 mo. | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ? Chronic liver disease ? ? Collagen Vascular disease 8 mo. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hyponatremia, metabolic acidosis. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/14/66 to 12/14/66 19_____, that (I) (we) last saw the deceased alive on 12/14/66 19_____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE C.H. Brown, III | | | M.O. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/14/66 |
| 23C. PHYSICIAN'S NAME (Type) C.H. BROWN 3RD | | | 23D. ADDRESS M.O. THE JOHNS HOPKINS HOSPITAL | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 12/17/66 | 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery | | 24D. LOCATION (City, town, or county) (State) Metport (Baltimore) Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 16 1966 | | 25B. NAME OF REGISTRAR Robert E. Jackson | | 25C. FUNERAL DIRECTOR ADDRESS Joseph L. Rues 2222 W. North Ave Baltimore, Md. | |



1
P-362

66 12575

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12575

BIRTH NO.

M.E. CASE NO.

| | | | | | | | |
|--|-------------------------|---|---|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) MARIE PATTERSON | | | | 2. DATE AND HOUR PRONOUNCED DEAD December 15, 1966 12:30 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 Lutheran Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 8415 Bellona Lane | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH May 14, 1914 | 9. AGE (in years last birthday) 52 | If Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary | | 10B. KIND OF BUSINESS OR INDUSTRY Office Work | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Henry Dantone | | | | 14. MOTHER'S MAIDEN NAME Margaret Wiedeck | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Harvey M. Patterson 8415 Bellona Ave. 21204 | | | |
| 18. CAUSE OF DEATH E 8164 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) (A) Multiple Traumatic Injuries. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) DUE TO | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Briarcliff Rd. & Baltimore Natl. Pike | | | |
| 21D. TIME OF INJURY (APPROX.) 12 14 '66 P | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? Driver in auto-auto collision. | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Petty | | M.D. Charles S. Petty | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 12/15/66 | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE Dec. 17, 1966 | | 23C. NAME of CEMETERY or CREMATORY Dulaney Valley Cemetery | | 23D. LOCATION (City, town, or county) (State) Cockeysville, Maryland | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | | 24C. FUNERAL DIRECTOR Wm. Cook-Brooks | | ADDRESS Towson 1050 York Road Towson, Maryland 21204 | |

May 10, 1914

Baltimore, Maryland

Harvey M. Patterson

Office Work

Secretary

Henry Gantson

no

RECEIVED
MAY 10 1914
U.S. DEPT. OF JUSTICE

Dec. 17, 1908 Baltimore Valley Cemetery Cockeysville, Maryland

Enclosed

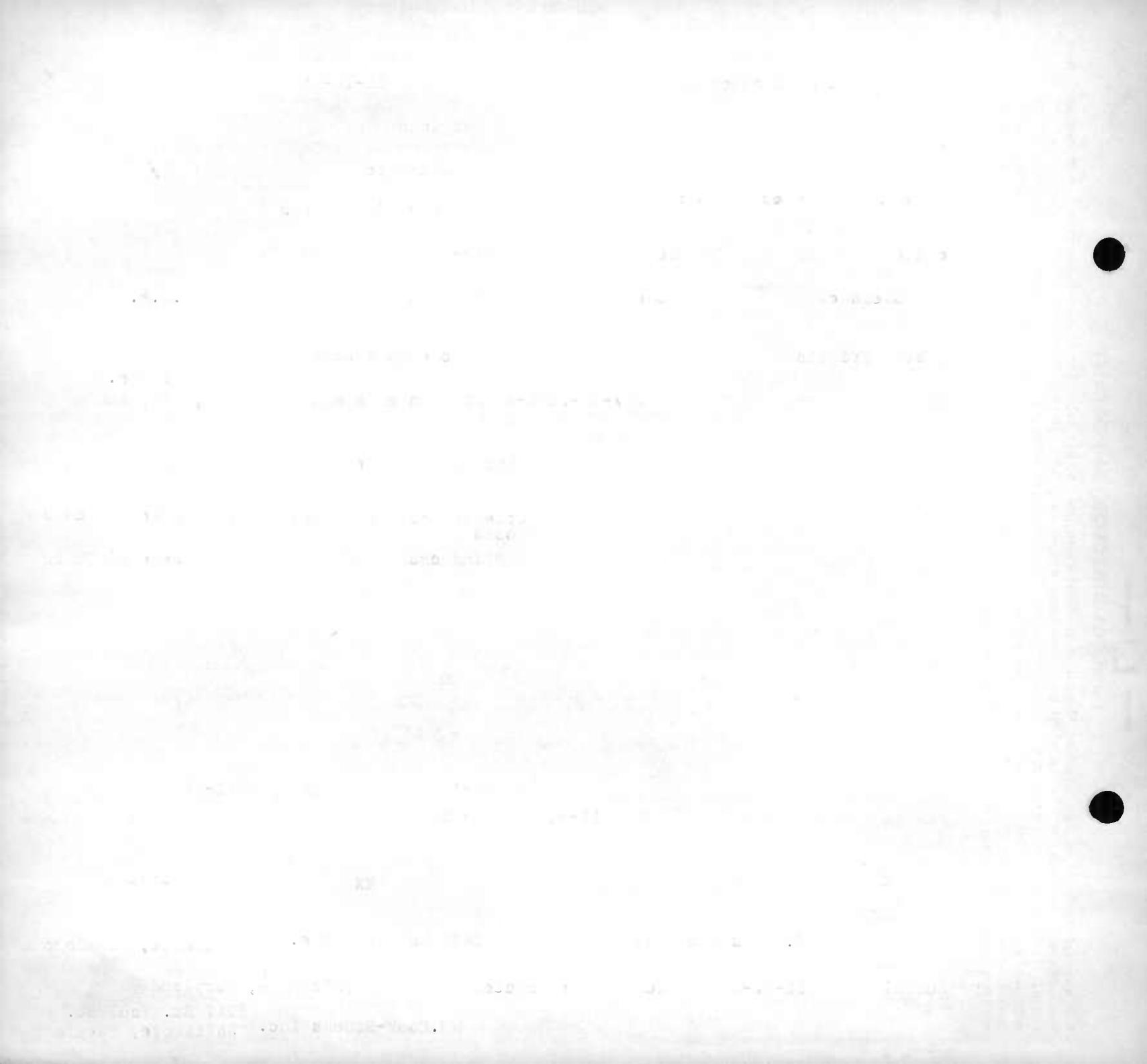
Wm. Cook-Brown's Tombstone 1030

London, England

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 12576</u> | |
|---|------------------------------|--|--|--|---|
| BIRTH NO. <u>66 12576</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Ethel Shanberger</u> | | 2. DATE AND HOUR OF DEATH <u>12-14-66</u> <u>8:00</u> p.m. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Bolton Hill Nursing Home</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>Roland View Towers</u> | | | |
| 5. SEX <u>Female</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>9-19-82</u> | 9. AGE (In years last birthday) <u>82</u> <u>84</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>Harry Francis</u> | | | 14. MOTHER'S MAIDEN NAME <u>Rebecca Ricaud</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>217-34-7208-A</u> | 17. INFORMANT <u>Mary Lake Sayers</u> <u>500 Talbot Ave. Laurel, Maryland</u> | | |
| 18. <u>42011</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>Coronary infarction</u> (A) DUE TO | | CAUSE OF DEATH <u>Cerebralvascular arteriosclerosis</u> (B) DUE TO <u>osis</u> <u>Blindness</u> (C) | | INTERVAL BETWEEN ONSET AND DEATH <u>few Minutes</u> <u>several Years</u> <u>several Years</u> | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>II</u> | | | | | |
| 19A. DATE OF OPERATION <u>No</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>No</u> | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12-1</u> <u>19 65</u> to <u>12-14</u> <u>19 66</u> , that (I) (we) last saw the deceased alive on <u>11-30</u> <u>19 66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>E. Ellsworth Cook</u> M.D. | | | | 23B. DATE SIGNED <u>12-16-66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>E. Ellsworth Cook</u> | | 23D. ADDRESS <u>2431 Maryland Ave. Baltimore, Maryland</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | 24B. DATE <u>12-17-66</u> | 24C. NAME OF CEMETERY or CREMATORY <u>Druid Ridge Cemetery</u> | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 16 1966</u> | | 25B. NAME OF REGISTRAR <u>E. Ellsworth Cook</u> | | 25C. FUNERAL DIRECTOR <u>WM. Cook-Brooks Inc. Baltimore, Maryland</u> | |



Relaxed to Medical Examiner for no secondary emergency from 12/11/66

NOT A MEDICAL EXAMINER'S CASE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause of death; (5) A physician who pronounced death was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--|---|--|--|--|
| 4-520 66 12577 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12577 | |
| BIRTH NO. 66 12577 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type in Print) <u>HAYNES, HAINES, MAY</u> | | | | <u>Dec 12. 66. 7. 55 P.M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>35 Church home & hospital 100 W. Broadway Baltimore.</u> | | | | A. STATE <u>Maryland</u> | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | |
| | | | | D. STREET ADDRESS (If rural, give location) <u>288 S. Spring St</u> | |
| 5. SEX <u>Female</u> | | 6. RACE <u>White</u> | | 8. DATE OF BIRTH <u>12/28/1893</u> | |
| | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Divorced</u> | | 9. AGE (in years lost birthday) <u>73 yrs</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>sewing, clothing</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>W. Va</u> | | 11. BIRTHPLACE (State or foreign country) <u>W. Va</u> | |
| 13. FATHER'S NAME <u>Not known</u> | | 14. MOTHER'S MAIDEN NAME <u>Not known</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A. America</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>Not known</u> | | 17. INFORMANT <u>K. M. Anandiah M.D.</u> | |
| 18. <u>491X I</u> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) <u>pneumonia R.M.L.</u> | | | |
| (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) | | (B) <u>Dehydration.</u> | | <u>Not known</u> | |
| ANTECEDENT CAUSES | | (C) <u>Aspiration pneumonia</u> | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Nat White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Dec 12 1966</u> to <u>Dec 12 1966</u> , that (I) (we) last saw the deceased alive on <u>Dec 12 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>K. M. Anandiah</u> M.D. | | | | 23B. DATE SIGNED <u>12/12/66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>K. M. ANANDIAH</u> M.D. | | | | 23D. ADDRESS <u>Church home & hospital Baltimore</u> | |
| 24A. <u>Cremation</u> | | 24B. DATE <u>12/16/1966</u> | | 24C. NAME OF CREMATORY <u>Green Mount</u> | |
| 24D. LOCATION (City, town, or county) <u>Baltimore Md.</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 16 1966</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Fairbank</u> | | 25C. FUNERAL DIRECTOR <u>W. C. Cook, Brokers Inc</u> | |
| | | | | 1217 St Paul St Baltimore 2 Md | |

RECEIVED
JAN 10 1964
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

11/11/63

Jan 12 1964

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Chlorine levels - high to
100 in laboratory
380 2. 380 12
Baltimore
Maryland

Not known
Unknown
Unknown
Not known
K. H. Brandenburg
Chlorine levels
11/11/63

Agitation
Deliberation
Furnace
K. H. Brandenburg

Dec 12

Dec 12

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Dec 12

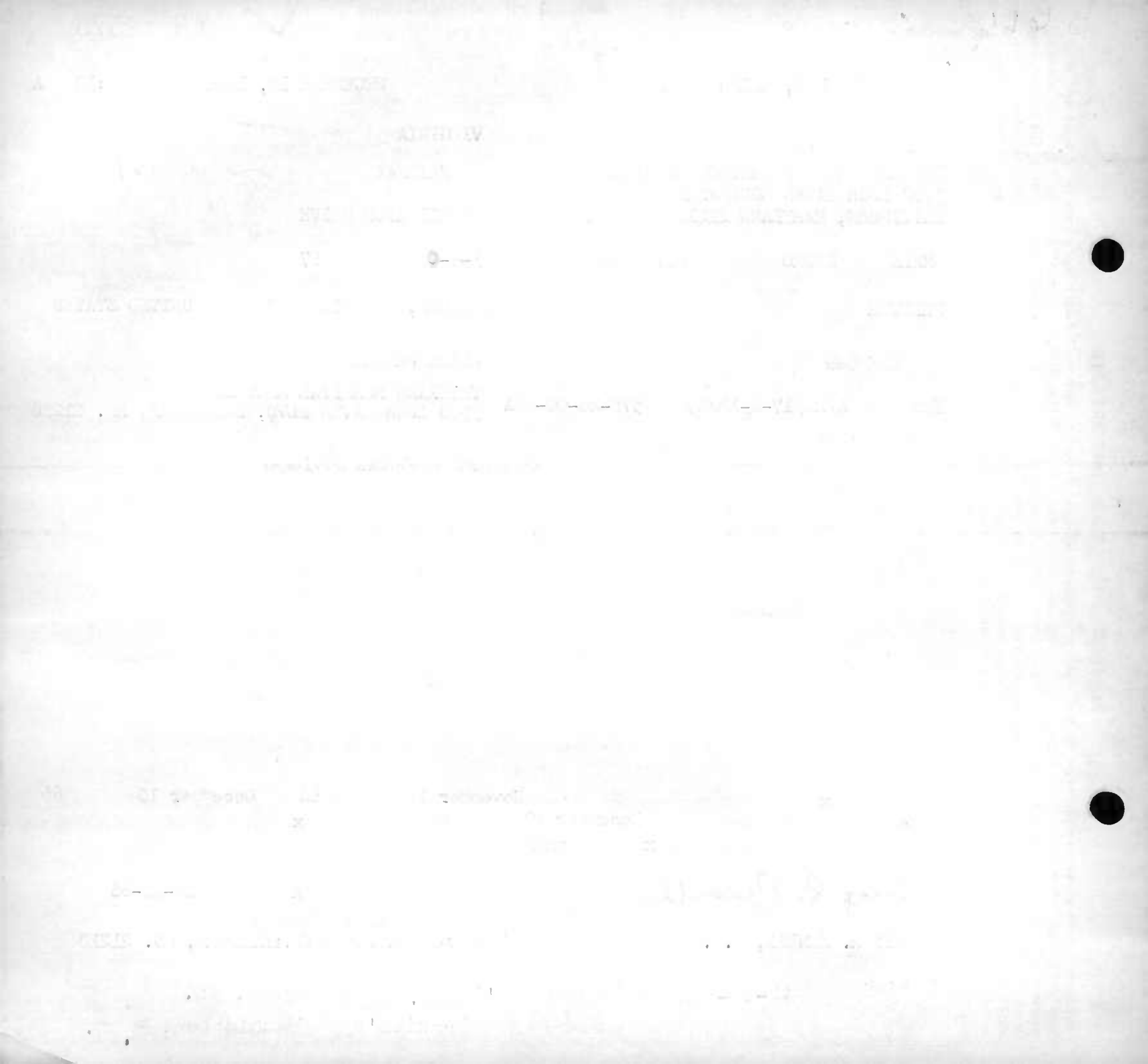
K. H. Brandenburg
K. H. Brandenburg

Chlorine levels - high to
12/12/63

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 12578 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12578 | |
|--|-------------------------|--|--|--|--|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) BARBER, RALPH NMN | | | | 2. DATE AND HOUR OF DEATH DECEMBER 10, 1966 3:10 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE VIRGINIA B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218 | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) FAIRFAX | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 10311 ZION DRIVE | | | |
| 5. SEX MALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) DIVORCED | 8. DATE OF BIRTH 3-9-09 | 9. AGE (In years lost birthday) 67 | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRINTER | | | 11. BIRTHPLACE (State or foreign country) MADISON, GEORGIA | | 12. CITIZEN OF WHAT COUNTRY? UNITED STATES | | |
| 13. FATHER'S NAME UNKNOWN | | | 14. MOTHER'S MAIDEN NAME ALICE BARBER | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 4/22/17-8/13/19 | | | 16. SOCIAL SECURITY NO. 578-26-00-86A | | 17. INFORMANT ADDRESS VETERANS HOSPITAL RECORDS 3900 LOCH RAVEN BLVD, BALTIMORE, MD. 21218 | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CEREBRAL VASCULAR ACCIDENT DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that NO (this hospital) attended the deceased from November 18 19 66 to December 10 19 66 , that NO (we) last saw the deceased alive on December 10 19 66 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (X) view the body after death. | | | | | | | |
| 23A. SIGNATURE Guy R. Newell | | | | | | 23B. DATE SIGNED 12-10-66 | |
| 23C. PHYSICIAN'S NAME (Type) GUY R. NEWELL, M.D. | | | | 23D. ADDRESS VETERANS HOSPITAL 3900 LOCH RAVEN BLVD, BALTIMORE, MD. 21218 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-15-66 | | 24C. NAME OF CEMETERY or CREMATORY Arlington Nat'l Cem. | | 24D. LOCATION (City, town, or county) (State) Arlington, Va. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 16 1966 | | 25B. NAME OF REGISTRAR Robert E. Frazier | | 25C. FUNERAL DIRECTOR Frazier's | | ADDRESS Washington, D. C. | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|--|--|--|--|--|--|
| BIRTH NO. 66 12579 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12579 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| HAYES, WILLIAM OLLIE | | DECEMBER 10, 1966 | | 5:20 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218 | | A. STATE MARYLAND B. COUNTY BALTIMORE | | | |
| 5. SEX MALE | | 6. RACE NEGRO | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) DIVORCED | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) BALTIMORE, MD. | |
| 13. FATHER'S NAME OLLIE HAYES | | 14. MOTHER'S MAIDEN NAME NELLIE JAMES | | 12. CITIZEN OF WHAT COUNTRY? UNITED STATES | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) YES 42 to 46 | | 16. SOCIAL SECURITY NO. 218-10-83-04 | | 17. INFORMANT VETERANS HOSPITAL RECORDS 3900 LOCH RAVEN BLVD, BALTIMORE, MD. 21218 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Tuberculosis, pulmonary, active DUE TO (B) Lung abscess DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH years | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from December 9 19 66 to December 10 19 66, that (X) (we) last saw the deceased alive on December 10 19 66 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death. | | 23A. SIGNATURE M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> Domingo A. Garcia DOMINGO A. GARCIA | | 23B. DATE SIGNED 12/12/66 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS M.D. VA Hospital 3900 Loch Raven Blvd Baltimore, Maryland 21218 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12/16/66 | | 24C. NAME of CEMETERY or CREMATORY Baltimore National | |
| 24D. LOCATION (City, town, or county) (State) 5501 Frederick Rd | | 25A. DATE REC'D BY HEALTH DEPT. DEC 16 1966 | | 25B. NAME OF REGISTRAR Robert E. Fairbank | |
| 25C. FUNERAL DIRECTOR Joseph B. Lock Jr | | 25D. ADDRESS 1304 N. Central St | | | |

A. J.

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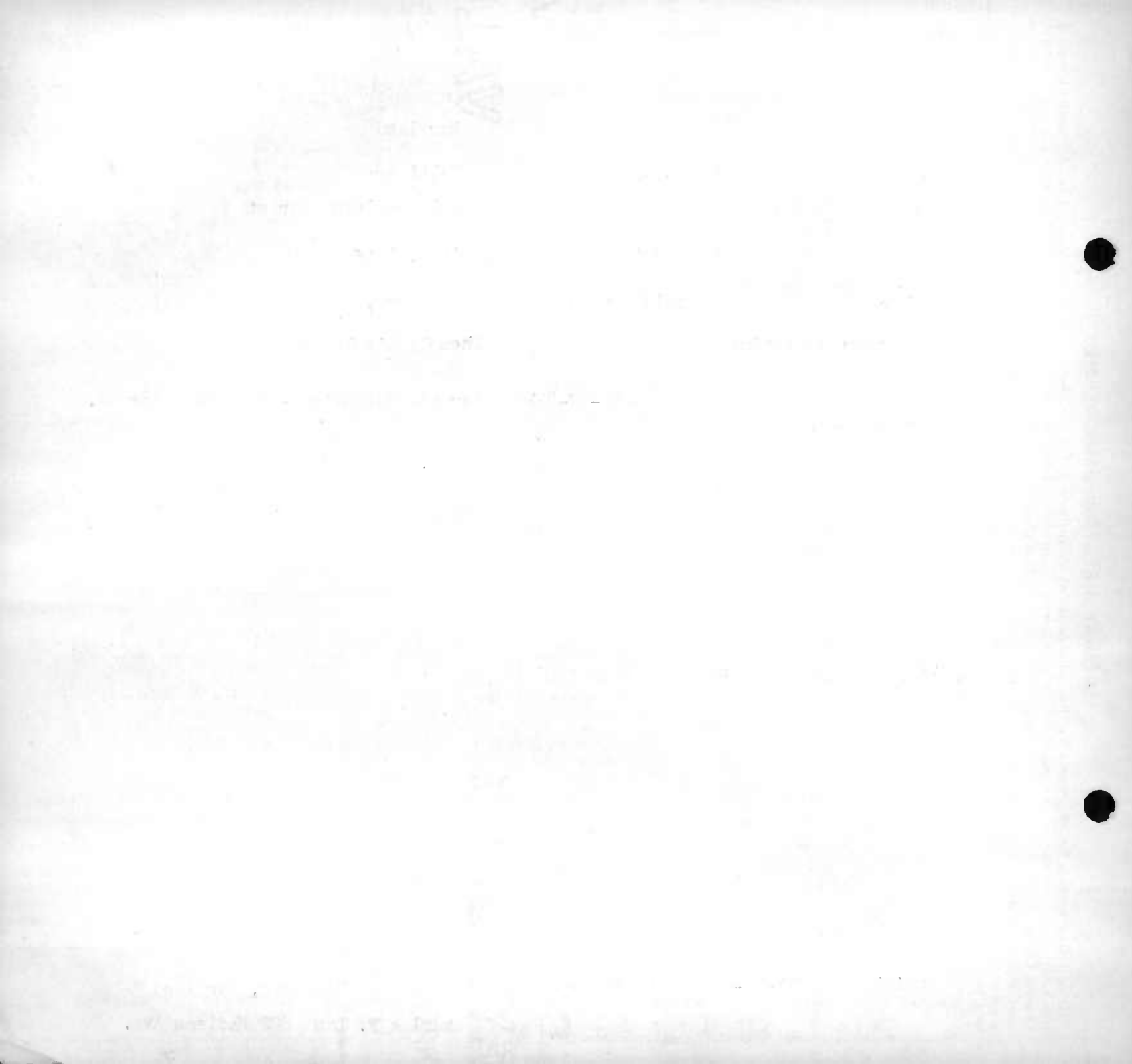
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12580 | |
|--|--|---|--|--|--|
| BIRTH NO. 66 12580 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Fosson, Lewis William | | 2. DATE AND HOUR OF DEATH 12-11-66 8:05 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) North Charles General Hosp. | | A. STATE Maryland | | B. COUNTY Baltimore | |
| 5. SEX Male | | 6. RACE American | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | |
| 8. DATE OF BIRTH 12-22-79 | | 9. AGE (In years last birthday) 86 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | |
| 11. BIRTHPLACE (State or foreign country) Kentucky | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Fosson HENRY W | |
| 14. MOTHER'S MAIDEN NAME SOPHIA BOBANG | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 235-05-9224 | |
| 17. INFORMANT Hospital Chart | | 18. CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) Cerebrovascular accident | | 22 days | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | DUE TO Thrombosis | | | |
| ANTECEDENT CAUSES | | (B) Hypertension, Atherosclerosis | | years | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | DUE TO cardio-vascular dr. | | | |
| C) _____ | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from 11-18-1966 to 12-11-1966, that (I) (we) lost saw the deceased alive on 8:05 A.M. - 12-11-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE M. M. McInnis | | 23B. DATE SIGNED 12-11-66 | |
| 23C. PHYSICIAN'S NAME (Type) ELLSWORTH COOK | | 23D. ADDRESS 2431 Maryland Ave | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12/14/66 | | 24C. NAME OF CEMETERY or CREMATORY BALTA | |
| 24D. LOCATION (City, town, or county) BALTO CO MD | | 24E. NAME OF REGISTERAR Robert E. Taylor | | 24F. FUNERAL DIRECTOR ADDRESS DAVID R. MARTIN 3021 GUILFORD AVE BALTO MD | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 12581</u> | |
|--|---------------------|--|--|---|---|
| BIRTH NO. <u>66 12581</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>HARRY A. VALENTINE</u> | | 2. DATE AND HOUR OF DEATH <u>12-13-66</u> <u>9:23 A</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>LUTHERAN HOSPITAL OF MARYLAND</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | | |
| | | D. STREET ADDRESS (If rural, give location) <u>16-04</u> <u>1013 Appleton Street</u> | | | |
| 5. SEX <u>M</u> | 6. RACE <u>N</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u> | 8. DATE OF BIRTH <u>April 7, 1905</u> | 9. AGE (In years last birthday) <u>61</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Social Security</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u> | |
| 13. FATHER'S NAME <u>Lawrence Valentine</u> | | | 14. MOTHER'S MAIDEN NAME <u>Phenola Singleton</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW II</u> | | 16. SOCIAL SECURITY NO. <u>216-07-8318</u> | | 17. INFORMANT ADDRESS <u>Loretta Valentine - 1013 Appleton St.</u> | |
| 18. <u>593X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Acute Renal Failure</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Hypotension</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>12-5-66</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Benign Prostatic Hypertrophy</u> | | 20A. AUTOPSY (Yes or No) <u>Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12-1-1966</u> to <u>12-13-1966</u> , that (I) (we) last saw the deceased alive on <u>12-13-1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Abraham A. Constantino</u> | | | | 23B. DATE SIGNED <u>12-13-66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>William Bint</u> | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12-16-66</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Baltimore National</u> | |
| | | | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 16 1966</u> | | 25B. NAME OF REGISTRAR <u>Charles R. Law</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>802 Madison Ave.</u> | |



BIRTH NO.

66 12582

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JAMES E. JOHNSON

2. DATE AND HOUR PRONOUNCED DEAD

11-19-66

7:00 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 ABOARD S.S. "NORINA"

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE B. COUNTY

Texas

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Port Arthur

D. STREET ADDRESS (If rural, give location)

Grace Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married

8. DATE OF BIRTH

4-8-08

9. AGE (In years
last birthday)

58

10. Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Crewman

10B. KIND OF BUSINESS OR INDUSTRY

Merchant Marine

11. BIRTHPLACE (State or foreign country)

Nokomis, Alabama

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Will W. Johnson

14. MOTHER'S MAIDEN NAME

Mary J. Seale

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Marine Corp. New York, New York

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☒ Inspection ☐ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

WERNER U. SPITZ, M.D.

CHIEF MEDICAL EXAMINER ☐
M.D. ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-13-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

12-16-66

23C. NAME of CEMETERY or CREMATORY

Sullivan Cemetery

23D. LOCATION

(City, town, or county)

Nokomis

(State)

Alabama

24A. DATE REC'D BY HEALTH DEPT.

DEC 16 1966

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

HOWARD H. HUBBARD

ADDRESS

4107 WILKENS AVE. 21229

Pronounced Maryland Dry Dock - 12/13/66

66 12583

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12583

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JACK COLE, Sr.

2. DATE AND HOUR PRONOUNCED DEAD

December 13, 1966 1:05 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

42 Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3616 Bowers Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

12/11/09

9. AGE (In years
last birthday)

67

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Self employed

10B. KIND OF BUSINESS OR INDUSTRY

Tavern

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Phillip Cole

14. MOTHER'S MAIDEN NAME

Sophie Kurland

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

217-16-3900

17. INFORMANT

ADDRESS

Harry Cole 1530 Pennsylvania Ave.

18. 422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breiteneker M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

12/14/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/15/66

23C. NAME OF CEMETERY or CREMATORY

Mikro Kodesh

23D. LOCATION (City, town, or county) (State)

Bowley's Lane

24A. DATE REC'D BY HEALTH DEPT.

DEC 16 1966

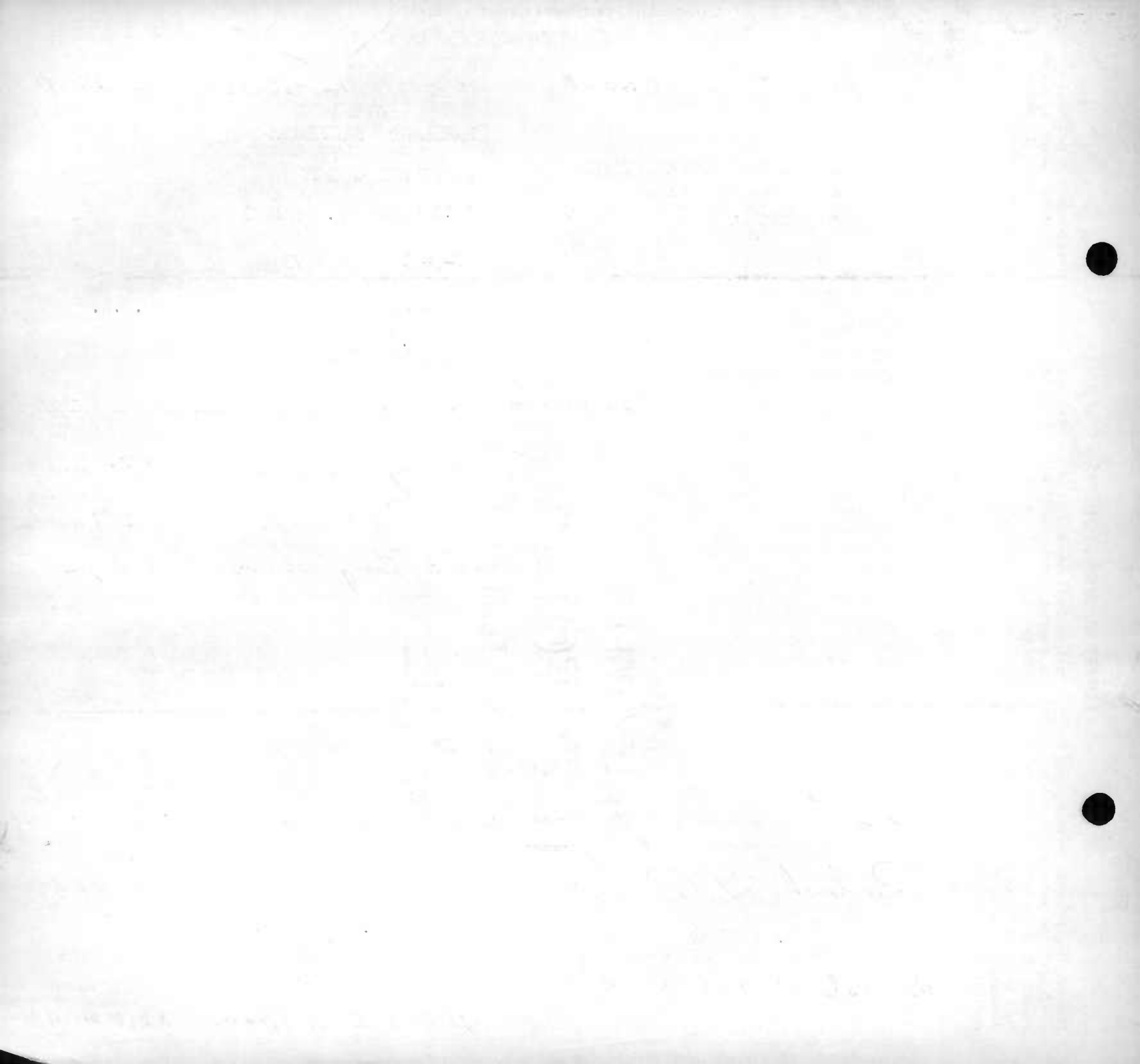
24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

JACK LEWIS, INC. 2100 Eutaw Place

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12585 | |
|---|------------------|--|-----------------------------|--|--|
| BIRTH NO. 66 12585 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) JOHNSON, LAWRENCE | | 2. DATE AND HOUR OF DEATH Dec. 15-66 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 46 LUTHERAN HOSPITAL OF MARYLAND | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 15-04 | | | |
| | | D. STREET ADDRESS (If rural, give location) 2412 2412 REISTERSTOWN RD | | | |
| 5. SEX MALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED WIDOWED DIVORCED (specify) | 8. DATE OF BIRTH 3/17/88 | 9. AGE (In years last birthday) 78 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) King William Co, VA | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME John Lewis Johnson | | 14. MOTHER'S MAIDEN NAME Louise Dixon | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO. | | 16. SOCIAL SECURITY NO. 233-05-3778A | | 17. INFORMANT Mrs. Elmore Bradley 2879 Gerritley Rd. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CERTIFICATION APPROVED BY O. Harker, Jr. M.D. CHIEF OF ASST. MEDICAL EXAMINER 11/30/66 | | CAUSE OF DEATH (A) PULMONARY EMBOLISM DUE TO EPNEUMONIA (B) DEEP VEIN PHLEBITIS OF LEFT LEG DUE TO INTERTROCHANTERIC FRACTURE OF LEFT HIP INTERVAL BETWEEN ONSET AND DEATH 23 DAYS | |
| 19A. DATE OF OPERATION 11/3/66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED FAIR | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Sidewalk | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Reisterstown Rd and Sykesville Fall (sidewalk) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) Oct. 28. 66 245 pm | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? Fell & slipped while walking on the street | |
| 22. I certify that (I) (this hospital) attended the deceased from Oct. 28 19 66 to Dec. 15 19 66, that (I) (we) last saw the deceased alive on Dec. 15 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Young Kil Kim | | | | 23B. DATE SIGNED 12/15/66 | |
| 23C. PHYSICIAN'S NAME (Type) YOUNG KIL KIM | | | | 23D. ADDRESS LUTHERAN HOSPITAL OF MARYLAND | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-18-66 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cem. A.A. Co. Md. | |
| 24D. LOCATION (City, town, or county) (State) Md. | | 25A. DATE REC'D BY HEALTH DEPT. DEC 16 1966 | | 25B. NAME OF REGISTRAR Robert E. Jackson | |
| 25C. FUNERAL DIRECTOR Mortimer Dyer H.F.H. | | 25D. ADDRESS 1701 Laurens | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12586 | |
|--|----------------------|--|-------------------------------------|---|---|
| BIRTH NO. 66 12586 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) MANSFIELD, ANNA OURT | | 2. DATE AND HOUR OF DEATH 12-15-66 9:35 a.m. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION The Union Memorial Hospital | | A. STATE MD B. COUNTY Baltimore Co. | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 10 53-00 | | | |
| | | D. STREET ADDRESS (If rural, give location) 6 Knoll Ridge Rd | | | |
| 5. SEX F | 6. RACE W. | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow | 8. DATE OF BIRTH 11-10-82 | 9. AGE (In years last birthday) 84 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) New Jersey | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Lewis Ourt | | 14. MOTHER'S MAIDEN NAME Anna Hall Bentley | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 161-07-2440 | | 17. INFORMANT MISS M. FRANCES MANSFIELD | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Ca of head of pancreas | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO | | (B) DUE TO | |
| (C) DUE TO | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 12-7-66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Gonorrhea | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from 12-7-66 to 12-15-66 , that (X) (we) last saw the deceased alive on 12-15-66 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Felix I. Martin | | | | 23B. DATE SIGNED 12-15-66 | |
| 23C. PHYSICIAN'S NAME (Type) Felix martin | | | | 23D. ADDRESS the union memorial hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/17/1966 | | 24C. NAME OF CEMETERY or CREMATORY Ivy Hill | |
| 24D. LOCATION Philadelphia, Pa. | | 24E. DATE REC'D BY HEALTH DEPT. | | 24F. NAME OF REGISTRAR | |
| 24G. DATE REC'D BY HEALTH DEPT. | | 24H. NAME OF REGISTRAR | | 24I. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Baltimore 12, Md. | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12587 | |
|---|-----------|---|---------------------------|--|--|
| BIRTH NO. 66 12587 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) TULL, NORA R | | 2. DATE AND HOUR OF DEATH DEC 15 1966 8A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 Md GEN HOSP. BALTO. Md. 21201 | | A. STATE Md B. COUNTY BALTO. C. CITY OR TOWN (If outside city limits, write RURAL and give township) 9-06 D. STREET ADDRESS (If rural, give location) 1800 E. 31st St. | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED | 8. DATE OF BIRTH 11/14/94 | 9. AGE (In years last birthday) 72 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE HOUSEWIFE - OWN HOME | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Md. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME George W Sellers 220-22-00120 | | 14. MOTHER'S MAIDEN NAME Sarah L. Stephens | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO YES WWI | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT Kenneth R Koskenen MD ADDRESS | |
| 18. 154 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH (A) METASTATIC CARCINOMA DUE TO (B) ADENOCARCINOMA OF RECTUM (C) | | INTERVAL BETWEEN ONSET AND DEATH 6 months | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION fast. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/08 1966 to 12/15 1966, that (I) (we) last saw the deceased alive on 12/15 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Kenneth R Koskenen MD M.D. | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/15/66 | |
| 23C. PHYSICIAN'S NAME (Type) Kenneth R. Koskenen M.D. | | 23D. ADDRESS Md GEN HOSP. BALTO., Md 21201. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/19/1966 | | 24C. NAME of CEMETERY or CREMATORY Druid Ridge | |
| 24D. LOCATION Pikesville, Balto. Co., Md. | | 25A. DATE REC'D BY HEALTH DEPT. DEC 16 1966 | | | |
| 25B. NAME OF REGISTRAR R. E. E. J. J. | | 25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Baltimore 12, Md. | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12588 | |
|--|---------------|---|---------------------------|---|--|
| BIRTH NO. 66 12588 | | CERTIFICATE OF DEATH | | Registered No. 66 12588 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Latney, Joyce Renee | | 2. DATE AND HOUR OF DEATH 12/9/66 1:10 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital | | D. STREET ADDRESS (If rural, give location) 131 Aisquith Street | | E. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| 5. SEX F | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Child | 8. DATE OF BIRTH 11-16-65 | 9. AGE (In years last birthday) 1yr | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | |
| 13. FATHER'S NAME David L. Latney | | 14. MOTHER'S MAIDEN NAME Sarah Covington | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT David L. Latney ADDRESS Same | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH ACUTE BRONCHOPNEUMONIA Cardiac arrest PSYCHOMOTOR RETARDATION Suffocation Possible aspiration | | INTERVAL BETWEEN ONSET AND DEATH 6 hrs | |
| 19A. DATE OF OPERATION 12/9/66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/9 to 12/9 1966 that (I) (we) last saw the deceased alive on 12/9 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE William C. MacLean, Jr. | | 23B. DATE SIGNED 12/9/66 | | 23C. PHYSICIAN'S NAME (Type) William C. MacLean, Jr. M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/14/66 | | 24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 12 1966 | | 25B. NAME OF REGISTRAR A. E. E. Phillips | | 25C. FUNERAL DIRECTOR 1727 N. Mount St. | |

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66 12589

BALTIMORE CITY HEALTH DEPARTMENT

66 12589

BIRTH NO. 66-24029 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print) LIONEL W. TRIPP2. DATE AND HOUR PRONOUNCED DEAD
December 9, 1966 10:15 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

42
99 Sinai Hospital (DOA)

D. STREET ADDRESS (If rural, give location)

Baltimore 27-16
4522 Finney Avenue5. SEX
Male6. RACE
Negro7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Single8. DATE OF BIRTH
11/7/19669. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.
1

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)
Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

William Tripp

14. MOTHER'S MAIDEN NAME

Mary C Tripp

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
William Tripp 4522 Finney Ave.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Interstitial pneumonitis (SDII)
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Charles S. Springate, M.D.
EXAMINER'S NAME (Type)CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

December 9, 1966

23A. BURIAL CREMATION, REMOVAL (Specify)

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION (City, town, or county) (State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

11/1/12
Butterfield
May 6 1899
William J. J. J.

11/1/12
Butterfield
May 6 1899
William J. J. J.

11/1/12
Butterfield
May 6 1899
William J. J. J.

11/1/12
Butterfield
May 6 1899
William J. J. J.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|--|-------------------------|---|---|---|--|
| BIRTH NO. 66 12590 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12590 | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) JOHN W. MYERS | | | DEC. 17, 1966 1 6:45 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY OF MARYLAND 38 HOSPITAL | | | A. STATE MD. B. COUNTY | | |
| (If not in hospital or institution, give street address or location) | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 14-03 | | |
| | | | D. STREET ADDRESS (If rural, give location) 2100 McCULLOH ST. | | |
| 5. SEX MALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED | 8. DATE OF BIRTH 10-3-1921 | 9. AGE (In years last birthday) 45 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNEMPLOYED | | | 10B. KIND OF BUSINESS OR INDUSTRY - | | 11. BIRTHPLACE (State or foreign country) MARYLAND |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 13. FATHER'S NAME THOMAS MYERS | | | 14. MOTHER'S MAIDEN NAME LILIE H. MURRAY | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN | | | 16. SOCIAL SECURITY NO. 219-01-9798 | | 17. INFORMANT THOMAS E. MYERS |
| ADDRESS SAME AS ABOVE | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH CARCINOMA OF STOMACH WITH METASTASES | | | INTERVAL BETWEEN ONSET AND DEATH 1 YEAR | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 - | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED - | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from DEC. 7, 1966 to DEC. 17, 1966 , that (I) (we) last saw the deceased alive on DEC. 7, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE John C. Dunkler, Jr. | | | | 23B. DATE SIGNED DEC. 17, 1966 | |
| 23C. PHYSICIAN'S NAME (Type) JOHN C. DUNKLER, JR. | | | | 23D. ADDRESS UNIV. OF MD. HOSP. 22 S. GREENE ST. 26201 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/17/66 | | 24C. NAME of CEMETERY or CREMATORY BROOKS CHAPEL | |
| 24D. LOCATION (City, town, or county) (State) Calverton Co Md | | 25A. DATE REC'D BY HEALTH DEPT. DEC 19 1966 | | 25B. NAME OF REGISTRAR Wesley E. Tolson | |
| 25C. FUNERAL DIRECTOR Manhart & Sons, 638 N. G. Street | | 25D. ADDRESS | | | |

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Don C. B. Smith
Don C. B. Smith

Barrett & Sons
Managerial & Administrative Services

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|--|-----------------------------|--|--|---|--|
| BIRTH NO. 66 12591 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 12591 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) John Gardenhire | | | 2. DATE AND HOUR OF DEATH 12-10-66 7:30A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland # 21224 | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 13-03 D. STREET ADDRESS (If rural, give location) 2516 Madison Ave. | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 8-8-08 | 9. AGE (In years last birthday) 58 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Tenn | |
| 13. FATHER'S NAME Marshall GARDENHIRE | | | 14. MOTHER'S MAIDEN NAME Mary Karrick | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 217-07-6806 | | 17. INFORMANT ADDRESS # 21224 Records: BCH 4940 Eastern Ave. Baltimore, Md. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Carcinoma of lung | | | (A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH MAY/66 - Dec/66 |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. BRONCHOMETASTASIS 2° to (C) | | | (B) DUE TO | | July/66 - Dec/66 |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | (C) DUE TO | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/8/66 to 12-10-66 that (I) (we) last saw the deceased alive on 12/10/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE David Swimmer | | | M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-10-66 |
| 23C. PHYSICIAN'S NAME (Type) David Swimmer | | | 23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland #21224 | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burnt | 24B. DATE 12/9/66 | 24C. NAME OF CEMETERY or CREMATORY MT CALVARY | | 24D. LOCATION (City, town, or county) (State) BROOKLYN BALTO 21235 MD | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 10 1966 | | 25B. NAME OF REGISTRAR W. E. Jackson | | 25C. FUNERAL DIRECTOR ADDRESS Manhattan p. Hy 20638 N. Gilmor St | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---|---------------------|--|-------------------------------------|---|---|
| BIRTH NO. 66 12592 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 12592 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) LEWIS L. GROSS / Lewis L. Gross | | 2. DATE AND HOUR OF DEATH 12-17-66 2:10 p.m. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 16-06 | |
| FULL NAME OF HOSPITAL OR INSTITUTION 4th Lutheran Hospital of Maryland | | D. STREET ADDRESS (If rural, give location) 603 W. LONGWOOD ST. | | | |
| 5. SEX M. | 6. RACE N | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Separated | 8. DATE OF BIRTH 12-14-92 | 9. AGE (In years last birthday) 34 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Portrait Painter | | 10B. KIND OF BUSINESS OR INDUSTRY Marine R.R. | | 11. BIRTHPLACE (State or foreign country) St Leonard, Calvert (Md) | |
| 13. FATHER'S NAME Calvert Gross | | 14. MOTHER'S MAIDEN NAME Mary Moore | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WWI | | 16. SOCIAL SECURITY NO. 215-10-9239 | | 17. INFORMANT Frances Johnson ADDRESS 3803 Roxbury Rd | |
| 18. 434.11 | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (A) Pulm. Embolism DUE TO | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) Congestive heart failure DUE TO | | | |
| (C) | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-9 19 66 to 12-17 19 66 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Lucas C. Vidhyaphum M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED 12-17-66 | |
| 23C. PHYSICIAN'S NAME (Type) LUCAS C. VIDHYAPHUM M.D. | | 23D. ADDRESS Lutheran Hospital of Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burn | | 24B. DATE 12/21/66 | | 24C. NAME of CEMETERY or CREMATORY BALTO NATIONAL BALTO MD | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 19 1966 | | 25B. NAME OF REGISTRAR R. E. Taylor | | 25C. FUNERAL DIRECTOR William P. Hays ADDRESS 638 N. GILMORE ST | |



FUNERAL DIRECTOR: IMPORTANT

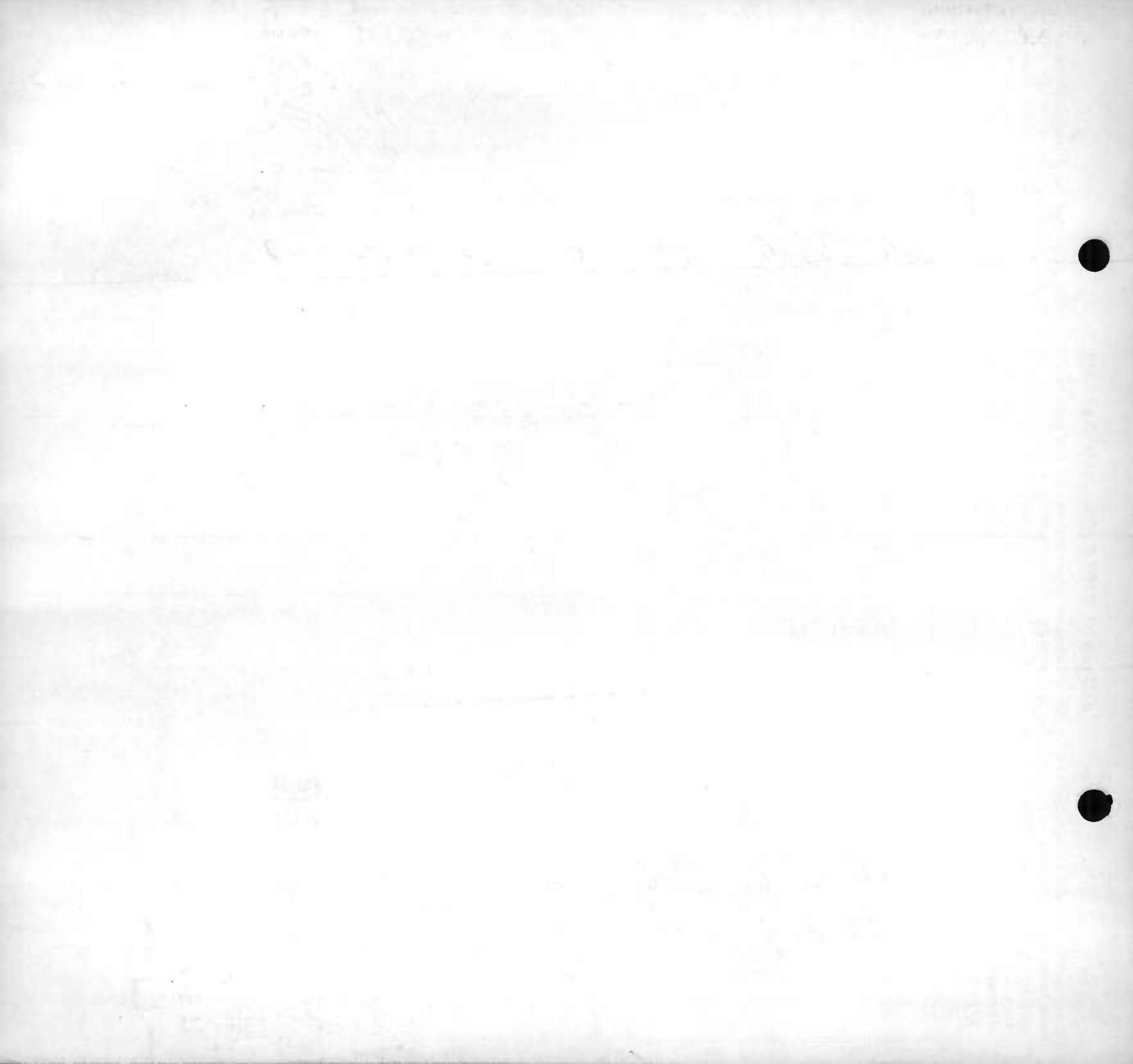
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 12593 | | CERTIFICATE OF DEATH | | Registered No. 66 12593 | |
|---|---------------------|--|-----------------------------------|--|--|
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Judy Ann Tydings | | 2. DATE AND HOUR OF DEATH Dec 17 1966 2:40 AM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | A. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE MD. B. COUNTY BALTOP | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) OWEN MILLS | |
| FULL NAME OF HOSPITAL OR INSTITUTION University Hospital | | D. STREET ADDRESS (If rural, give location) OWING | | E. CITY OR TOWN (If outside city limits, write RURAL and give township) 33-00 | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) never married | 8. DATE OF BIRTH 7/2/59 | 9. AGE (In years last birthday) 7 yrs | 10. If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) child | | 10B. KIND OF BUSINESS OR INDUSTRY child | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Nelson Tydings | | 14. MOTHER'S MAIDEN NAME Sherley A. Stallings | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. n/a | | 17. INFORMANT MR. NELSON H. TYDINGS | |
| 18. 751.21 | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO meningitis | | 3 weeks | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO hydrocephalic | | 7 years | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | hydrocephalous | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec 13 1966 to Dec 14 1966 , that (I) (we) lost saw the deceased alive on Dec 14 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Martha Leffler | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED Dec. 14, 1966 | |
| 23C. PHYSICIAN'S NAME (Type) MARTHA LEFFLER | | M.D. | | 23D. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12/16/66 | | 24C. NAME OF CEMETERY OR CREMATORY ALL HALLOWS CEM. | |
| 24D. LOCATION (City, town, or county) (State) BIRDSVILLE A A CO MD | | 24E. DATE REC'D BY HEALTH DEPT. | | 24F. NAME OF REGISTRAR JOHN M. TAYLOR | |
| 24G. FUNERAL DIRECTOR ADDRESS ANNAPOLIS MD | | 24H. DATE DEC 19 1966 | | 24I. NAME OF REGISTRAR JOHN M. TAYLOR | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 12594</u> | |
|--|-------------------------|--|--|---|---|
| BIRTH NO. <u>66 12594</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>JERRY LUNAK</u> | | 2. DATE AND HOUR OF DEATH <u>12-13-66 2:00 A.M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Huthuran Hospital of Maryland</u> | | A. STATE <u>Maryland</u> | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore 26-03</u> | | | |
| | | D. STREET ADDRESS (If rural, give location) <u>3842 Elmora av.</u> | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u> | 8. DATE OF BIRTH <u>4-14-94</u> | 9. AGE (In years last birthday) <u>72</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most at working life, even if retired) <u>Parking Attendant</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Hutzler's</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u> | |
| 13. FATHER'S NAME <u>Emil Lunak</u> | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>220-22-6517A</u> | | 17. INFORMANT ADDRESS <u>Hazel Reese Lunak, wife, above</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>331X I</u> <u>0 EVA.</u> | | CAUSE OF DEATH (A) DUE TO <u>0 EVA.</u> (B) DUE TO <u>2 Peptic ulcer & hemorrhage</u> (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Amos C. Vidhyaphum</u> | | | | 23B. DATE SIGNED <u>12-13-66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>AMOS C VIDHYAPHUM</u> | | | | 23D. ADDRESS <u>Huthuran Hospital of Maryland</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12/16/66</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Baltimore National Cem</u> | |
| | | | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 19 1966</u> | | 25B. NAME OF REGISTRAR <u>R. E. Feltner</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>Schimunek Funeral Home, Inc. 3331 Biehms Lane</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|--|--|--|--|
| BIRTH NO. 66 12595 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12595 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Helen Rose H. Treadwell | | | 2. DATE AND HOUR OF DEATH 12/14/66 4:40 PM | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 26-03 D. STREET ADDRESS (If rural, give location) 3321 Dudley Ave. | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital | | | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 5/20/75 | 9. AGE (In years last birthday) 91 | 10. Under 1 Yr. Months Days Hours Min. 11 Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY at home | | 11. BIRTHPLACE (State or foreign country) Bel Air, Md. | |
| 13. FATHER'S NAME Patrick Dunnigan | | | 14. MOTHER'S MAIDEN NAME Annie Hunt | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Walter J. Treadwell, son, above | |
| 18. 153.8 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) renal failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Anemia, Uremia ASCVD, CA | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/11 to 12/14 19 66 , that (I) (we) last saw the deceased alive on 12/14/66 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE F. Ismail Beigi | | | 23B. DATE SIGNED 12/14/66 | | |
| 23C. PHYSICIAN'S NAME (Type) F. Ismail Beigi | | | 23D. ADDRESS The Johns Hopkins Hospital | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/17/66 | | 24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery | |
| 24D. LOCATION Baltimore, Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR Schimunek Funeral Home, Inc. | | 25C. FUNERAL DIRECTOR ADDRESS 3331 Brehms Lane | |

1/24/67 - Co. of Colon - see letter from
J. H. H. in Doc's file - Bur. of
Re-statistics - American Bldg.
8st.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 66 12596 | | 66 12596 | |
|--|--|--|--|---|--|--|--|
| BIRTH NO. | | | | 66 12596 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| (Type or Print) | | | | GEORGE AUGUST TORNEY, SR. | | Dec. 13, 1966 9:45 a. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | | | A. STATE B. COUNTY | | | |
| (If not in hospital or institution, give street address or location) | | | | Md. 21218 | | | |
| 44 Union Memorial Hospital | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | | | 735 Melville Ave. 9-03 | | | |
| D. STREET ADDRESS (If rural, give location) | | | | Baltimore, | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | |
| male | | white | | married | | 4/24/1890 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Inspector | | B & O R. R. | | Baltimore, Md. | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Albert Torney | | | | Caroline Hinkel | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| no | | | | 705-05-7447 | | Cecelia Piller Torney, wife, above | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) DUE TO | | 8 yrs | |
| ANTECEDENT CAUSES | | | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) DUE TO | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| O | | | | No | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from December 19 48 to Dec. 13, 1966, that (I) (we) last saw the deceased alive on Dec. 2, 1966 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | | | 23B. DATE SIGNED | |
| Morris B. Schreiber | | | | | | 12-13-66 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | | 23D. ADDRESS | |
| Dr. Morris B. Schreiber | | | | | | 1519 W. Lombard Street | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 12/16/66 | | Bel Air Mem. Gardens | | Bel Air, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | | | |
| | | DEC 18 1966 | | Schimunek Funeral Home, Inc. | | 3331 Brehms Lane | |

October 10, 1911

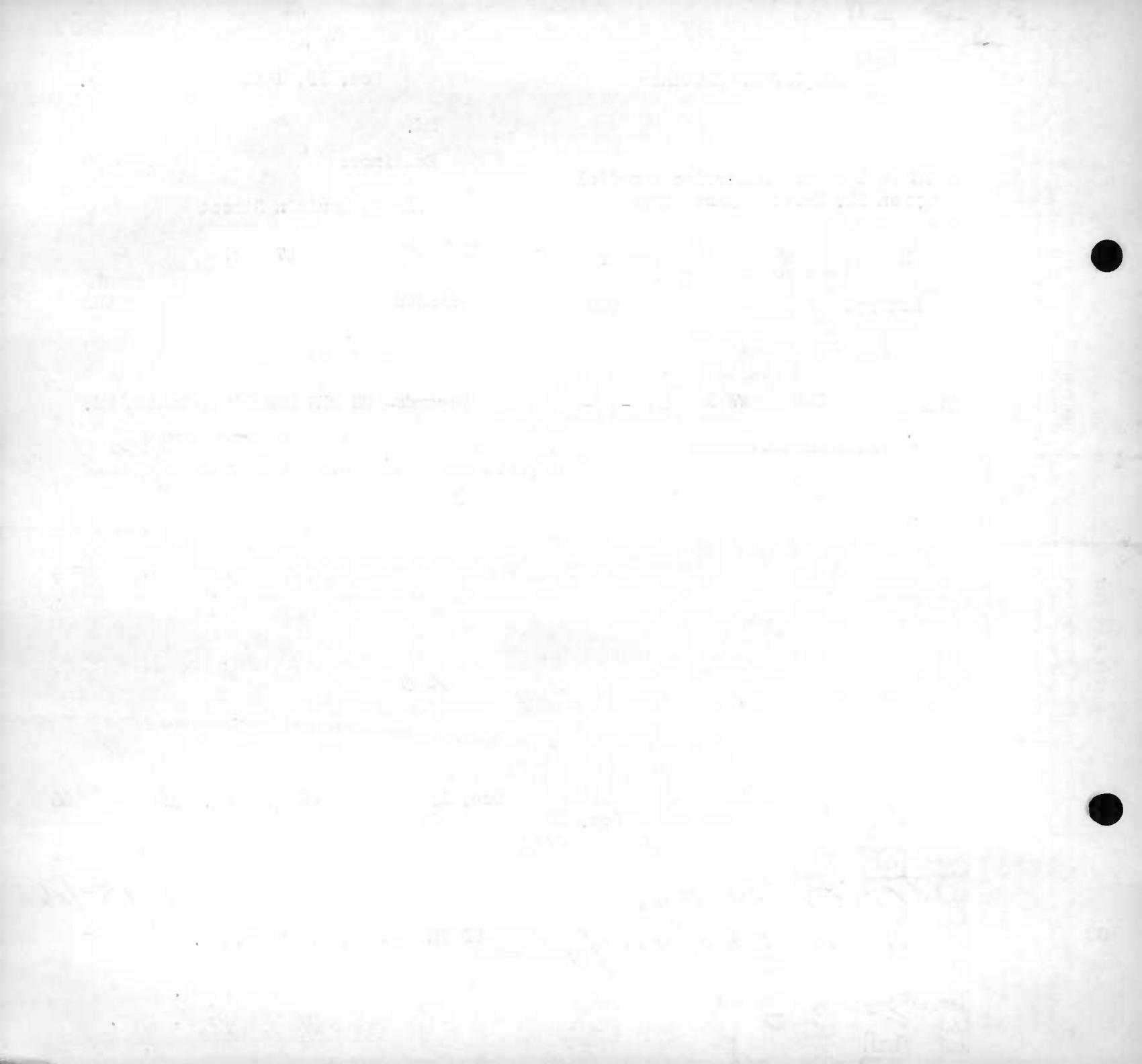
Dear Mr. [illegible]

X

Very truly yours,

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

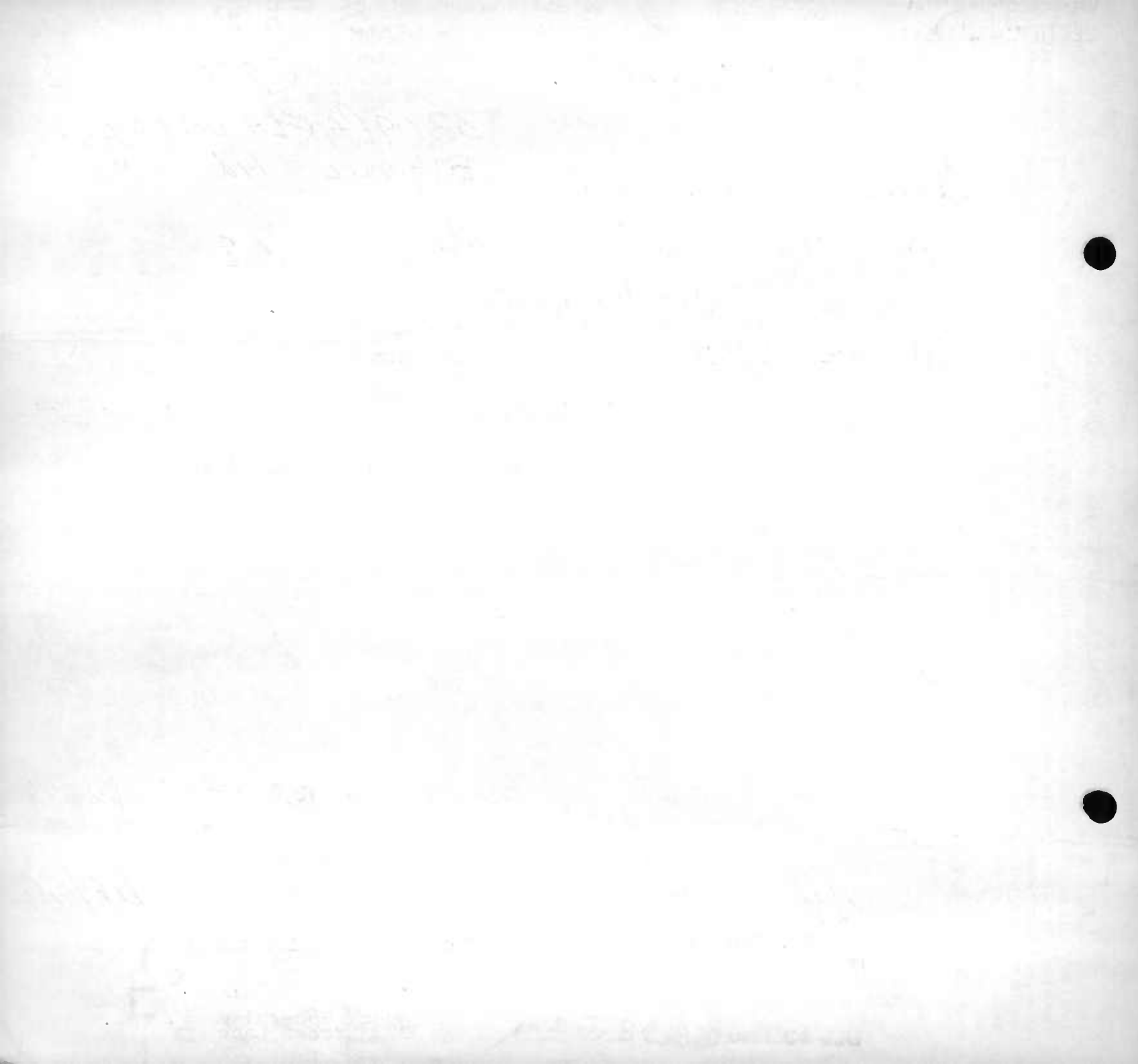
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. | |
|--|--|--------------|--|--|--|---|--|---|--|--|--|
| BIRTH NO. 66 12597 | | | | | | | | | | 66 12597 | |
| M.E. CASE NO. | | | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) Ralph John Blattner | | | | | | 2. DATE AND HOUR OF DEATH Dec. 15, 1966 | | | | 6 p. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION US Public Health Service Hospital Wyman Pk. Drive & 31st Street | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | | | |
| | | | | | | D. STREET ADDRESS (If rural, give location) 510 N. Bouldin Street | | | | | |
| 5. SEX M | | 6. RACE W | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | | 8. DATE OF BIRTH 12/4/79 | | 9. AGE (In years last birthday) 87 | | 10. Under 1 Yr. Months: Days: Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | | | 10B. KIND OF BUSINESS OR INDUSTRY USN | | 11. BIRTHPLACE (State or foreign country) Kansas | | | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME unknown | | | | | | 14. MOTHER'S MAIDEN NAME unknown | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes USN WW I | | | | 16. SOCIAL SECURITY NO. 216-32-3719A | | 17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md. | | | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>Arteriosclerotic Heart Disease</i> | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec. 15 1966 to Dec. 15 1966, that (I) (we) last saw the deceased alive on Dec. 15 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE <i>M. D. Bellamy</i> | | | | | | | | | | 23B. DATE SIGNED 12-15-66 | |
| 23C. PHYSICIAN'S NAME (Type) M. D. Bellamy | | | | | | 23D. ADDRESS US PHS Hospital, Balto, Md. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | 24B. DATE 12/19/66 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore National Cem | | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR <i>DEC 19 1966</i> | | | | 25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12598 | |
|---|------------------|--|--|--|--|
| <div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. 66 12598</p> <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) FRANK C. Vogel Sr.</p> </div> <div> <p>2. DATE AND HOUR OF DEATH 12/16/66 8:20</p> </div> </div> | | | | | |
| <p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hosp.</p> | | | <p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE MD. B. COUNTY BALTIMORE</p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore Md. 801</p> <p>D. STREET ADDRESS (If rural, give location) 21213</p> | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) M | 8. DATE OF BIRTH 4/4/08 | 9. AGE (In years last birthday) 58 | <p>If Under 1 Yr. Months Days</p> <p>If Under 24 Hrs. Hours Min.</p> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Repair Man | | 10B. KIND OF BUSINESS OR INDUSTRY C&P Telephones | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | |
| 13. FATHER'S NAME Michael Vogel | | | 14. MOTHER'S MAIDEN NAME Barbara Gross | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 212-03-6802 | | 17. INFORMANT ADDRESS Elizabeth Marchant Vogel, wife, above | |
| <p>18. 420.1 I</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> | | | <p>CAUSE OF DEATH</p> <p>(A) myocardial infarction</p> <p>DUE TO</p> <p>(B) DUE TO</p> <p>(C) DUE TO</p> <p>INTERVAL BETWEEN ONSET AND DEATH</p> | | |
| <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p> | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| <p>22. I certify that (I) (this hospital) attended the deceased from 7:25 Am 12/16/66 to 8:30 Am 12/16/66, that (I) (we) last saw the deceased alive on 12/16/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p> | | | | | |
| 23A. SIGNATURE [Signature] | | | | 23B. DATE SIGNED 12/16/66 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Owellen | | 23D. ADDRESS The Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/19/66 | | 24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cem. | |
| | | | | 24D. LOCATION (City, town, or county) Baltimore, Md. (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 3331 Brehms Lane | |



66 12599

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12599

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JULIUS

PROEGER

2. DATE AND HOUR PRONOUNCED DEAD

December 13, 1966

8:05 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

37 Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

710 Cathedral Street THE ALCAZAR

Room 702

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

SINGLE

8. DATE OF BIRTH

APR. 14, 1885

9. AGE (In years
last birthday)

81

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

RETIRED TIME, STORE KEEPER-BELVEDERE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

GERMANY

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

UNKNOWN

HOTEL

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

BERNARD G. PETER

MD. APART. BK. BLDG
10 LIGHT ST.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)(A) Hypertensive Cardiovascular Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breiteneker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/14/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

12/16/66

23C. NAME of CEMETERY or CREMATORY

NEW CATHEDRAL CEMETERY

23D. LOCATION

(City, town, or county)

(State)

BALTIMORE, MD.

24A. DATE REC'D BY HEALTH DEPT.

DEC 19 1966

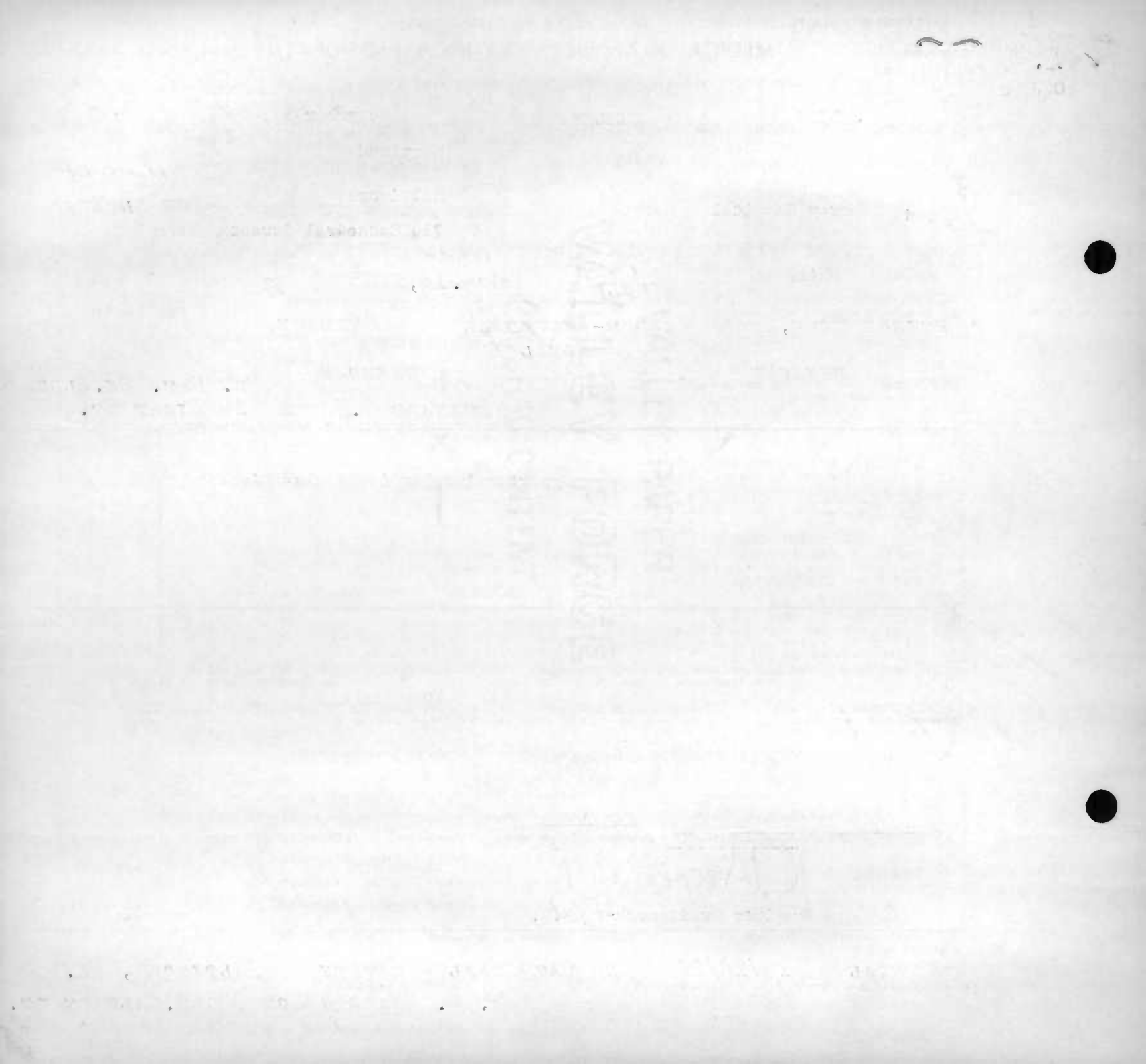
24B. NAME OF REGISTRAR

R. E. F. J. J.

24C. FUNERAL DIRECTOR

H. W. MEARS & SON 805 N. CALVERT ST.

ADDRESS



1
5-530

66 12600

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12600

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM H. SMITH

2. DATE AND HOUR PRONOUNCED DEAD

12-5-66

6:22 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

SOUTH BALTIMORE GENERAL HOSPITAL-DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

413 Scott Street 21230

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

June 5 1909

9. AGE (In years
last birthday)

57

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

machinist

10B. KIND OF BUSINESS OR INDUSTRY

Trailer Co.

11. BIRTHPLACE (State or foreign country)

Rogersville, Tenn.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Sam Smith

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown. If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

408-14-8335

17. INFORMANT

Ray C. Galvan, Annapolis, Md.

ADDRESS

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoarthritis, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

(B) DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

WERNER U. SPITZ, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-5-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12-8-66

23C. NAME OF CEMETERY or CREMATORY

Savage Cem.

23D. LOCATION

Savage Md.

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

DEC 19 1966

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

De Witt Sanderson, Laurel Md.

ADDRESS

WALLEY EPPER

WALLEY FORGE

WALLEY FORGE

WALLEY

WALLEY

WALLEY

WALLEY

WALLEY

WALLEY

WALLEY

WALLEY

WALLEY

WALLEY

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WALLEY

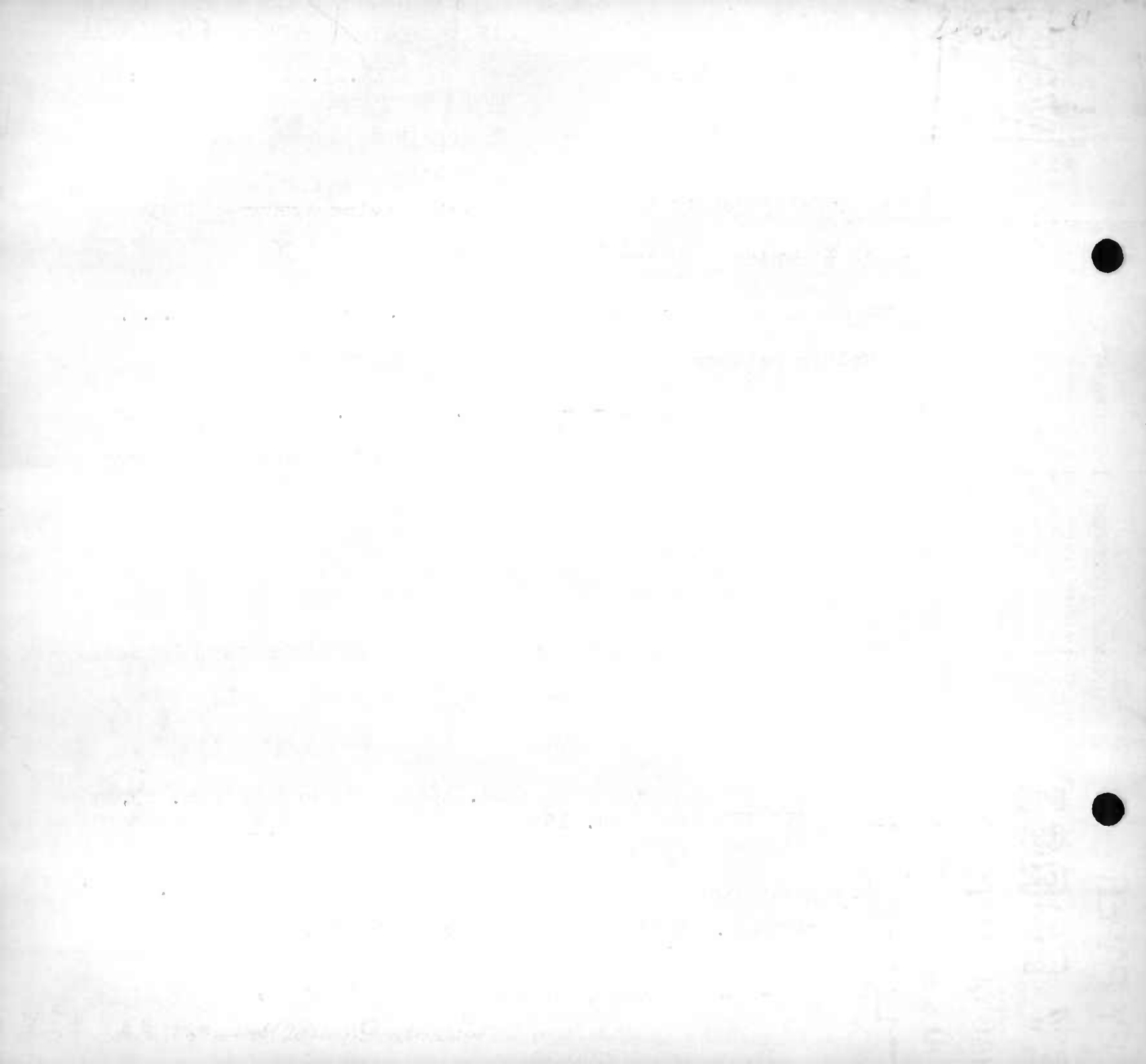
WALLEY

WALLEY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|------------------|--|-----------------------------|--|---|--|--|
| BIRTH NO. 66 12601 | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 66 12601 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Loretta Watkins | | | | 2. DATE AND HOUR OF DEATH 12.15.66 9:10 M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hohns Hopkins Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1323 Taylor Avenue 21234 | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 6/10/30 | 9. AGE (In years last birthday) 36 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress | | 10B. KIND OF BUSINESS OR INDUSTRY Sheridan | | 11. BIRTHPLACE (State or foreign country) Bayrd W. Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Walter Gaither | | | | 14. MOTHER'S MAIDEN NAME Lenora Bonner | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 220-10-1258 | | 17. INFORMANT Mr. Vincent E. Watkins 1323 Taylor Ave | | | |
| 18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Malignant Melanoma | | | | INTERVAL BETWEEN ONSET AND DEATH 4 mos | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) DUE TO (B) DUE TO (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec. 10 1966 to Dec. 15 1966 that (I) (we) last saw the deceased alive on Dec. 15 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Robert M. Winslow M.D. | | | | 23B. DATE SIGNED 12.15 | | 23C. PHYSICIAN'S NAME (Type) Robert M. Winslow M.D. | |
| 23D. ADDRESS Johns Hopkins Hospital | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-19-66 | | 24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 19 1966 | | 25B. NAME OF REGISTRAR R. L. E. Farley | | 25C. FUNERAL DIRECTOR Address 7401 Belair Road | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--------------------------------|--|---|--|--|
| BIRTH NO. 66 12602 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 12602 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) MR CURRY, TIMOTHY W. | | 2. DATE AND HOUR OF DEATH 12-15-66 2:15AM M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY HOWARD Co. | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL WILKENS & CATON AVES. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) SAVAGE | | D. STREET ADDRESS (If rural, give location) 63-00 COMMERCIAL ST. | |
| 5. SEX MALE | 6. RACE CAUCASION | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 01-24-85 | 9. AGE (In years lost birthday) 81 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY? U S A |
| 13. FATHER'S NAME JOHN CURRY | | | 14. MOTHER'S MAIDEN NAME SENR (NEE CURRY) | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 213-09-7985 | 17. INFORMANT ADDRESS MR. AGNES RECORDS, WILKENS & CATON AVES | | |
| 18. 608X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary Embolism 1 hr. | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 12-6-66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Arterial stricture | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from DECEMBER 2 19 66 to DECEMBER 15 19 66 , that (I) (we) lost saw the deceased alive on DECEMBER 15 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Ramon U. Suarez | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-15-66 | |
| 23C. PHYSICIAN'S NAME (Type) RAMON U. SUAREZ | | 23D. ADDRESS M.D. ST. AGNES HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 12-18-1966 | 24C. NAME of CEMETERY or CREMATORY Savage | | 24D. LOCATION (City, town, or county) (State) Savage, Md | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 19 1966 | | 25B. NAME OF REGISTRAR F.C. Higginbotham | | 25C. FUNERAL DIRECTOR'S ADDRESS F.C. Higginbotham, Ellicott City, Md | |

11-11-68

11-15-68

11-15-68

HOWARD

11-15-68

11-15-68

11-15-68

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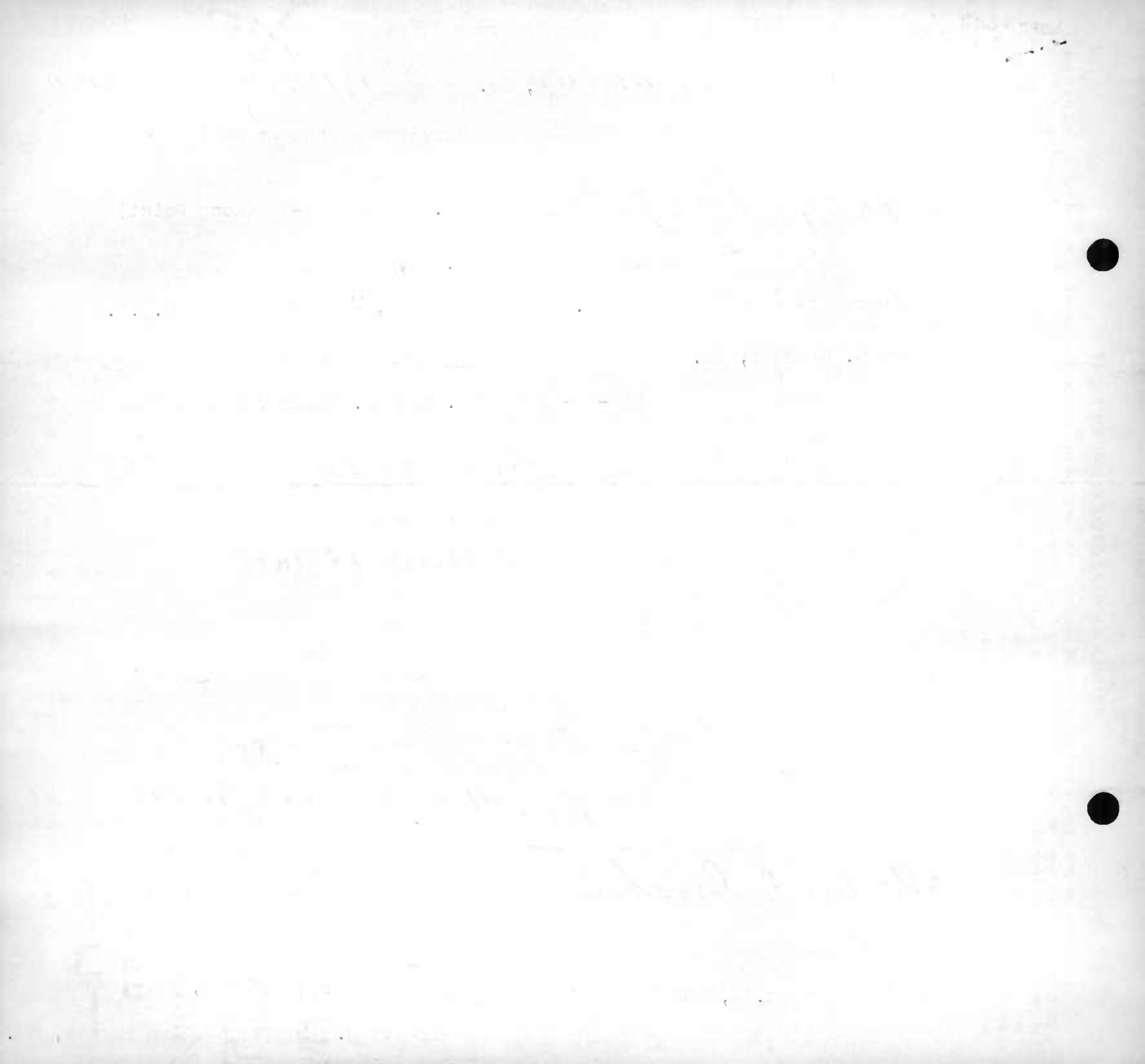
11-15-68

11-15-68

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|--|------------------|---|-----------------------------------|--|---|
| BIRTH NO. 66 12603 | | CERTIFICATE OF DEATH | | 66 12603 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) John Henry Glaeser, Jr. | | 2. DATE AND HOUR OF DEATH 12/13/66 8:15 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 37 Mercy Hospital. | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Anne Arundel Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Pasadena 52-00 D. STREET ADDRESS (If rural, give location) Rt. #1 Box #238-D (Long Point) | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH Aug. 16, 1918 | 9. AGE (In years last birthday) 48 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver | | 10B. KIND OF BUSINESS OR INDUSTRY Produce Co. | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME John H. Gleaser, Sr. | | 14. MOTHER'S MAIDEN NAME Magdaline Myers | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None | | 16. SOCIAL SECURITY NO. 218-18-4378 | | 17. INFORMANT ADDRESS Mrs. Ruth L. Gleaser (wife) Same as #2 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 581.01 Hemorrhage - Upper GI | | CAUSE OF DEATH (A) DUE TO Esophageal Varices (B) DUE TO Cirrhosis of Liver (C) | | INTERVAL BETWEEN ONSET AND DEATH 2 hrs. | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II | | | | | |
| 19A. DATE OF OPERATION None | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 11/16/66 to 12/13/66, that (I) (we) last saw the deceased alive on 12/13/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Philip B. Draski M.D. | | | | 23B. DATE SIGNED 12/13/66 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Dec. 17, 1966 | | 24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery | |
| 24D. LOCATION Brooklyn RFD, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 18 1966 | | 25B. NAME OF REGISTRAR G. E. Taylor | | 25C. FUNERAL DIRECTOR Richard V. Singleton | |
| | | | | ADDRESS Glen Burnie, Md. | |



66 12604

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12604

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

RICHARD CARROLL

2. DATE AND HOUR PRONOUNCED DEAD

12-12-66

8:30 A.. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)33
99
JOHNS HOPKINS HOSPITAL - DOA4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE
B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

832 N. Spring Street

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

5/11/28

9. AGE (In years
last birthday)

38

10. Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balt. Md

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

RICHARD CARROLL

14. MOTHER'S MAIDEN NAME

Carrie Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

ANITA PAIGE 936 Abbott CT

18. 443X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic and hypertensive
cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CAUTION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

EXAMINER'S

NAME (Type) WERNER U. SPITZ, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-12-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

12/17/66

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary

23D. LOCATION

(City, town, or county)

A.D. County, Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

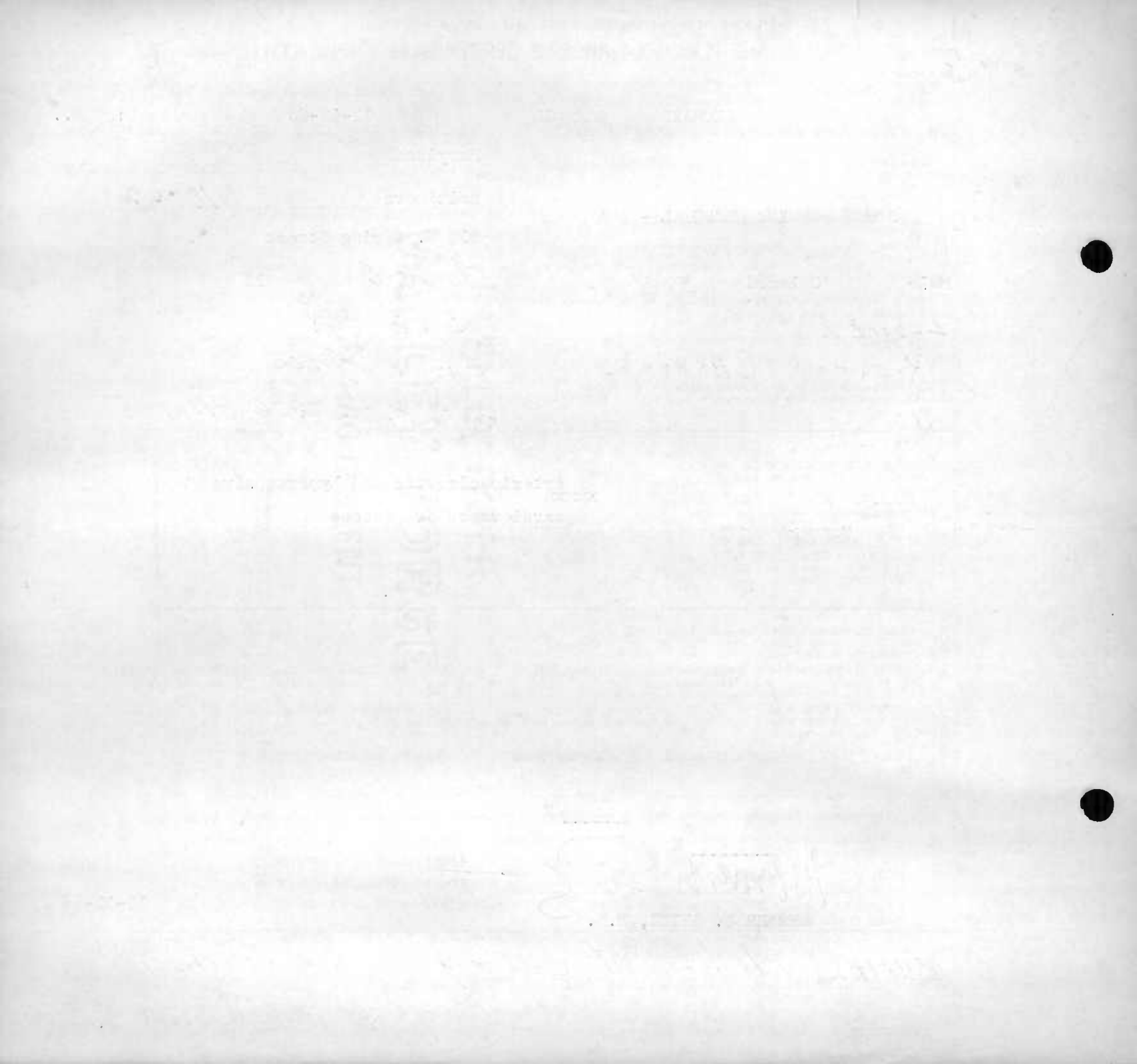
24C. FUNERAL DIRECTOR

ADDRESS

DEC 19 1966

Robert E. Finkbeiner

Joseph B. Locks 13042 Central Ave



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|--|-----------------------------------|---|---|
| BIRTH NO. 66 12605 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12605 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) BUSCH, BERNARD L. | | 2. DATE AND HOUR OF DEATH DECEMBER 16, 1966 6:35P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL CATON AND WILKENS AVENUES BALTIMORE, MD. 21229 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 28-41 D. STREET ADDRESS (If rural, give location) SETON INSTITUTE | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 3-7-91 | 9. AGE (In years last birthday) 75 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | 10B. KIND OF BUSINESS OR INDUSTRY NONE | | 11. BIRTHPLACE (State or foreign country) - UNKNOWN - Red Wing, Minn. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | 13. FATHER'S NAME FREDERICK BUSCH | | 14. MOTHER'S MAIDEN NAME ANNA (WEIMER) | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) - ? - | | 16. SOCIAL SECURITY NO. 220-54-6950 | | 17. INFORMANT ADDRESS ST AGNES RECORDS WILKENS & CATON AVE | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 177X I CAUSE OF DEATH (A) <i>Chronic lymphocytic leukemia</i> (B) <i>Cancer of prostate</i> (C) <i>Exacerbation of the above</i> INTERVAL BETWEEN ONSET AND DEATH | | 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 12/16/66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from DECEMBER 12, 1966 to DECEMBER 16, 1966 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on DECEMBER 16, 1966 and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (dXXX) view the body after death. | | | | | |
| 23A. SIGNATURE <i>[Signature]</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/16/66 | |
| 23C. PHYSICIAN'S NAME (Type) DR MOHAMMAD NICKBAHT | | 23D. ADDRESS M.D. ST AGNES HOSPITAL WILKENS & CATON AVE | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) burial | | 24B. DATE abt-Dec-20-66 | | 24C. NAME OF CEMETERY or CREMATORY St. Mark's | |
| 24D. LOCATION Shakopee, Minn. | | 25A. DATE REC'D BY HEALTH DEPT. | | | |
| 25B. NAME OF REGISTRAR <i>[Signature]</i> | | 25C. FUNERAL DIRECTOR ADDRESS Stewart & Mowen Co-108-W-North-Av-21201 | | | |

0:55

DECEMBER 18, 1953

DECEMBER 18, 1953

NOV 18 1953

11:10 AM

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DECEMBER 18, 1953

DECEMBER 18, 1953

66 12606

BALTIMORE CITY HEALTH DEPARTMENT

66 12606

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

GEORGE M. VALIS

2. DATE AND HOUR PRONOUNCED DEAD

December 12, 1966 6:45 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 2119 E. North Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4204 Sheldon Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

1903

9. AGE (In years last birthday)

63

10. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Restauranteur

10B. KIND OF BUSINESS OR INDUSTRY

Restaurant

11. BIRTHPLACE (State or foreign country)

Greece

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Michael

14. MOTHER'S MAIDEN NAME

Antheppe Moniodis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Yes

World War II

16. SOCIAL SECURITY NO.

—

17. INFORMANT

Mrs. Stamatia Valis

ADDRESS

4204 Sheldon Ave, Baltimore Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Gunshot Wound of Chest.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Restaurant

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

2119 E. North Avenue

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)
12 12 '66 P

21E. INJURY OCCURRED

WHILE AT WORK ☒ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

Shot in chest.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL SIGNATURE
EXAMINER'S NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/13/66

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

12/16/66

23C. NAME of CEMETERY or CREMATORY

Greek Orthodox Cemetery Baltimore, Md.

23D. LOCATION (City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

NICHOLAS T. MATTHEWS

ADDRESS

3021 Eastern Ave, Baltimore, Md.

WALLACE GORGE

WALLACE PAPER

WALLACE COMPANY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|--|--|--|---|--|---|--|--|--|---|--|
| BIRTH NO. 66 12607 | | | | | CERTIFICATE OF DEATH | | Registered No. 66 12607 | | | |
| 1. NAME OF DECEASED (Type or Print) HENRY E. SCHMAUS | | | | | 2. DATE AND HOUR OF DEATH 12/13/66 3:20 A.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME & Hospital 35 | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTO. | | | | | |
| 5. SEX MALE | | | | | 6. RACE WHITE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | | 8. DATE OF BIRTH 1/28/94 | |
| 9. AGE (In years, last birthday) 72 | | | | | 10. AGE (In years, last birthday) 72 | | 11. BIRTHPLACE (State or foreign country) BROOKLYN, NEW YORK | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) IRON WORKER | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | | 11. BIRTHPLACE (State or foreign country) BROOKLYN, NEW YORK |
| 13. FATHER'S NAME JOHN G. SCHMAUS | | | | | 14. MOTHER'S MAIDEN NAME MARY ANN FREIDEL | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | | 16. SOCIAL SECURITY NO. 212-05-5099 | | 17. INFORMANT EVAN SCHMAUS | | ADDRESS SAME | |
| 18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ARTERIOSCLEROTIC Cardio-vascular disease & atrial fibrillation, old myocardial infarction & congestive heart failure | | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II | | | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. AZOTEMIA | | | | | |
| 19A. DATE OF OPERATION 0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/5 19 66 to 12/13 19 66 , that (I) (we) last saw the deceased alive on 12/13 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE Francisco Baltazar M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | | | | | 23B. DATE SIGNED 12/13/66 | | |
| 23C. PHYSICIAN'S NAME (Type) FRANCISCO BALTAR M.D. | | | | | | 23D. ADDRESS CHURCH HOME & Hospital. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | 24B. DATE 12-16-66 | | | 24C. NAME OF CEMETERY or CREMATORY SACRED HEART CEM. | | | 24D. LOCATION (City, town, or county) (State) BALTO. CO., MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | 25B. NAME OF REGISTRAR Charles E. Taylor | | | 25C. FUNERAL DIRECTOR Charles E. Taylor | | | ADDRESS 901 S. CONKLIN ST. BALTO. 24, MD. | |

1941-1942

1941-1942

1941-1942

BURIAL - 12 - CC SACRED HEART CHURCH

1941-1942

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|---|--|---|---|
| BIRTH NO. 66 12608 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 12608 | |
| 1. NAME OF DECEASED (Type or Print) VOLECSKO, CATHERINE | | | 2. DATE AND HOUR OF DEATH 12-15-66 7:06A M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 ST. AGNES HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE ZONE 27 D. STREET ADDRESS (If rural, give location) 147 ELIZABETH AVENUE | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED MARRIED WIDOWED DIVORCED (specify) | 8. DATE OF BIRTH 1-22-1900 | 9. AGE (In years lost birthday) 66 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY at home | | 11. BIRTHPLACE (State or foreign country) NEW YORK | |
| 13. FATHER'S NAME Unknown | | | 14. MOTHER'S MAIDEN NAME Unknown | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ✓ | | 16. SOCIAL SECURITY NO. ✓ | | 17. INFORMANT ST. AGNES RECORDS-CATON & WILKENS AVE 29 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac arrest ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, CVA | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from DECEMBER 14 19 66 to DECEMBER 15 19 66 , that (I) (we) last saw the deceased alive on DECEMBER 15 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE A.B. HOOTON M.D. | | | | 23B. DATE SIGNED 12-15-1966 | |
| 23C. PHYSICIAN'S NAME (Type) A.B. HOOTON | | 23D. ADDRESS St. Agnes Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/19/66 | | 24C. NAME OF CEMETERY or CREMATORY Landon Park Cemetery Baltimore Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 19 1966 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR John J. Corwain & Son Inc. 231 N. Hollins St. Baltimore Md. | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 12609</u> | |
|---|-------------------------|---|---|--|--|
| BIRTH NO. <u>66 12609</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Charles H. Clarke</u> | | 2. DATE AND HOUR OF DEATH <u>12-12-66</u> <u>15:45 A.</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Bolton Hill Nursing Home</u> <u>90</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>853 West 34th Street</u> <u>13-06</u> | | | |
| 5. SEX <u>M</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>Mar 30, 1892</u> | 9. AGE (In years last birthday) <u>74</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Paper Hanger</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Contractor</u> | | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | | 13. FATHER'S NAME <u>Albert Clarke</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Lillian Level</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | |
| 16. SOCIAL SECURITY NO. <u>215-12-0274</u> | | 17. INFORMANT <u>Franklin L. Clarke - 326 Stemmers Run Rd. (21</u> | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>emphysema</u> INTERVAL BETWEEN ONSET AND DEATH <u>several yrs.</u> | | 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>generalized arteriosclerosis</u> <u>several yrs.</u> | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | 21. MEDICAL CERTIFICATION | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>no</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12-12-1965</u> to <u>12-13-1966</u> , that (I) (we) last saw the deceased alive on <u>12-5-1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>E. Elsworth Cook</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>12-14-66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>E. Elsworth Cook</u> | | 23D. ADDRESS <u>2431 Maryland Avenue</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>Dec 16, 1966</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Woodlawn Cemetery</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u> | | 25A. DATE REC'D BY HEALTH DEPT. | | | |
| 25B. NAME OF REGISTRAR <u>Frank H. Serty</u> | | 25C. FUNERAL DIRECTOR <u>814 W 36th St</u> | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 12610 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12610 | |
|---|-------------------------|---|---|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) Elmer Harper | | | | 2. DATE AND HOUR OF DEATH Dec 13 1966 8⁰⁰ P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE MARYLAND 21224 | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 829 W. 36th Street - 21211 | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 8/11/92 | 9. AGE (In years last birthday) 74 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | |
| 13. FATHER'S NAME FRANK HARPER | | | 14. MOTHER'S MAIDEN NAME WILHELM | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. 213-16-9825-A | | 17. INFORMANT RECORDS: BCH, 4940 Eastern Ave, Balto. Md. 21224 | | |
| 18. 143X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Sepsis | | | | CAUSE OF DEATH (A) DUE TO Abdominal (B) DUE TO Tracheobronchitis, Wall Maceration (C) Carcinoma of Floor of Mouth 2 yrs | | INTERVAL BETWEEN ONSET AND DEATH 1 wk | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Rebilitatin, Chronic Lung Disease | | | | | | | |
| 19A. DATE OF OPERATION July 1965 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED resection of Carcinoma | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 11/22 1966 to 12/13 1966 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12/13 1966 and that <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) <input checked="" type="checkbox"/> (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Joseph Silva | | | | M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/13/66 | |
| 23C. PHYSICIAN'S NAME (Type) JOSEPH SILVA | | | | 23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 Eastern Avenue, Balto. Md. 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/17-66 | | 24C. NAME OF CEMETERY or CREMATORY Woodlawn | | 24D. LOCATION (City, town, or county) (State) Baltimore City Md | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR DEC 19 1966 | | 25C. FUNERAL DIRECTOR Frank J. Seitz | | ADDRESS 814 W 36th St | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 12611</u> | |
|--|-------------------------|---|-------------------------------------|--|--|
| BIRTH NO. <u>66 12611</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>RAY, ANDREW (Andrew William Ray)</u> | | 2. DATE AND HOUR OF DEATH <u>DECEMBER 16, 1966</u> <u>5:40</u> P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <u>ST AGNES HOSPITAL</u> (If not in hospital or institution, give street address or location) | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>6203 MOYER AVENUE</u> | | | |
| 5. SEX <u>MALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Separated</u> | 8. DATE OF BIRTH <u>10/31/97</u> | 9. AGE (In years lost birthday) <u>69</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. NONE Maritime</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>NONE</u> | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>UNKNOWN Wojciech Fiksak</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>UNKNOWN Bronislawa Kot</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>(4430-0528) WW1-WW11</u> | | | |
| 16. SOCIAL SECURITY NO. <u>098-12-2497</u> | | 17. INFORMANT <u>Mrs. Anna Materewicz 6203 Moyer Ave.</u> <u>ST AGNES RECORDS WILKENS & CATON AVE</u> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>330X IV-134X</u> | | CAUSE OF DEATH (A) DUE TO <u>Parkinson's disease</u> (B) DUE TO <u>Possible Cancer of Rectum</u> (C) <u>dehydration and malnutrition</u> | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? <u>III in Baltimore City, give exact location</u> | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from <u>12/8</u> 19 <u>66</u> to <u>12/16</u> 19 <u>66</u> , that (IX) (we) last saw the deceased alive on <u>12/16</u> 19 <u>66</u> and that in (mX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>NICKBACHT</u> M.D. | | | | 23B. DATE SIGNED <u>12/16/66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>DR MOHAMMAD NICKBACHT</u> | | 23D. ADDRESS <u>ST. AGNES HOSPITAL-CATON & WILKENS AVENUE</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12/20/66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>St. Stanislaus Cemetery</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 19 1966</u> | | | |
| 25B. NAME OF REGISTRAR <u>Robert E. Fashy</u> | | 25C. FUNERAL DIRECTOR <u>George A. Weber 705 S. Ann St</u> | | | |

11-11-1950

WASH DC

SECRET

TO: DIRECTOR

FROM: SAC

SUBJECT: [illegible]

WHITE

[illegible]

[illegible]

[illegible]

[illegible]

11-11-1950

THE BUREAU OF INVESTIGATION

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 66 12612 | |
|---|------------------|--|--|--|--|--|--|
| BIRTH NO. 66 12612 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) EDWARD HERMAN STRANZ | | 2. DATE AND HOUR OF DEATH 12/14/66 6:45 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION FRANKLIN SQUARE HOSPITAL 36 | | (If not in hospital or institution, give street address or location) | | A. STATE MARYLAND | | B. COUNTY BALTO Co. | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-00 | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 7120 MARSTON ROAD | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. <input checked="" type="checkbox"/> MARRIED, NEVER MARRIED <input type="checkbox"/> WIDOWED, <input type="checkbox"/> DIVORCED (specify) | | 8. DATE OF BIRTH 2/18/1892 | | 9. AGE (In years lost birthday) 74 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mechanic | | 10B. KIND OF BUSINESS OR INDUSTRY machine shop | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME REINHOLD STRANZ (DECEASED) | | | | 14. MOTHER'S MAIDEN NAME SADIE TRUCHEL (DECEASED) | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) MYOCARDIAL INFARCTION DUE TO (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 11/16 1966 to 12/14 1966, that (I) (we) last saw the deceased alive on 12/14 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Thomas A. Alvero | | | | M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/14/66 | |
| 23C. PHYSICIAN'S NAME (Type) THOMAS A. ALVERO | | | | 23D. ADDRESS FRANKLIN SQUARE HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/17/66 | | 24C. NAME of CEMETERY or CREMATORY Loudon Park | | 24D. LOCATION (City, town, or county) (State) Balt. Md | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 19 1966 | | 25B. NAME OF REGISTRAR M. E. F. J. J. | | 25C. FUNERAL DIRECTOR Loring Byers | | ADDRESS 8728 Tubby Rd. | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 12613 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | X | | Registered No. 66 12613 | |
|--|-------------------------|--|--|--|---|---|------------------------------|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) JOSEPH H RAY | | | | | | 2. DATE AND HOUR OF DEATH Dec. 14, 1966 M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 St. Agnes Hospital | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Howard AA | | | |
| | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Linthicum 52-00 | | | |
| | | | | | | D. STREET ADDRESS (If rural, give location) 1319 Furnace Road | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 9-18-1880 | 9. AGE (In years last birthday) 86 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | | 10B. KIND OF BUSINESS OR INDUSTRY Telephone Co | | 11. BIRTHPLACE (State or foreign country) Wilna, Md | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME Frank Ray | | | | 14. MOTHER'S MAIDEN NAME Lillie M. Jordan | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 212-05-0667 | | 17. INFORMANT ADDRESS Joseph Ray, Monrovia, Md | | | | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) MYOCARDIAL INFARCTION SUDDEEN DUE TO GENERALIZED ARTERIOSCLEROSIS DUE TO DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from July 19 49 to 8 Dec 66 and that (I) (we) last saw the deceased alive on 8 Dec 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE George E. Groleau M.D. | | | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 15 Dec 66 | |
| 23C. PHYSICIAN'S NAME (Type) GEORGE E. GROLEAU M.D. | | | | | | 23D. ADDRESS MAIN ST ELTRIDGE MD | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-17-1966 | | 24C. NAME of CEMETERY or CREMATORY Prospect Hill | | 24D. LOCATION (City, town, or county) (State) Towson, Md | | | |
| 25A. DATE RECEIVED BY HEALTH DEPT. DEC 19 1966 | | | 25B. NAME OF REGISTRAR Robert E. Farkner | | | 25C. FUNERAL DIRECTOR F.C. Higinbotham, Ellicott City, Md | | | |
| ADDRESS 1319 Furnace Road | | | | | | | | | |

CERTIFICATE OF DEATH

Registered No.

66 12614

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

JESSE BOBLITZ

2. DATE AND HOUR OF DEATH

DEC 11, 1966 11:50 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

31

BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE, MARYLAND

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

Balt. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

53-00

D. STREET ADDRESS (If rural, give location)

1047 ARNCLIFFE RD #21221

5. SEX

MALE

6. RACE

WHITE

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

DIVORCED

8. DATE OF BIRTH

10/21/08

9. AGE (In years
last birthday)

58

If Under 1 Yr.

Months

Days

If Under 24 Hrs.

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

TRUCK DRIVER

10B. KIND OF BUSINESS OR INDUSTRY

Self Employed

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

EUGENE C. BOBLITZ

14. MOTHER'S MAIDEN NAME

ANNA JONES

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

None

16. SOCIAL
SECURITY NO.

17. INFORMANT

#21224

ADDRESS

RECORDS-BCH-4940 EASTERN AVENUE, BALTIMORE, MD.

18. 163 X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) CARCINOMA OF LUNG
DUE TO

18 months +

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(B)
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) ~~(this hospital)~~ attended the deceased from DECEMBER 11 1966 to DECEMBER 11 1966,
that (I) (we) last saw the deceased alive on DECEMBER 11 1966 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) ~~(we)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE

Alan J. Barnes

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

December 12, 1966

23C. PHYSICIAN'S
NAME (Type)

Dr. Alan J. Barnes

M.D.

23D. ADDRESS

BALTIMORE CITY HOSPITALS

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

Dec. 15, 1966

24C. NAME OF CEMETERY OR CREMATORY

Carroll's Methodist Cemetery

24D. LOCATION

(City, town, or county)

(State)

Reisterstown, Md.

25A. DATE REC'D BY HEALTH DEPT.

DEC 12 1966

25B. NAME OF REGISTRAR

R. E. Fairbank

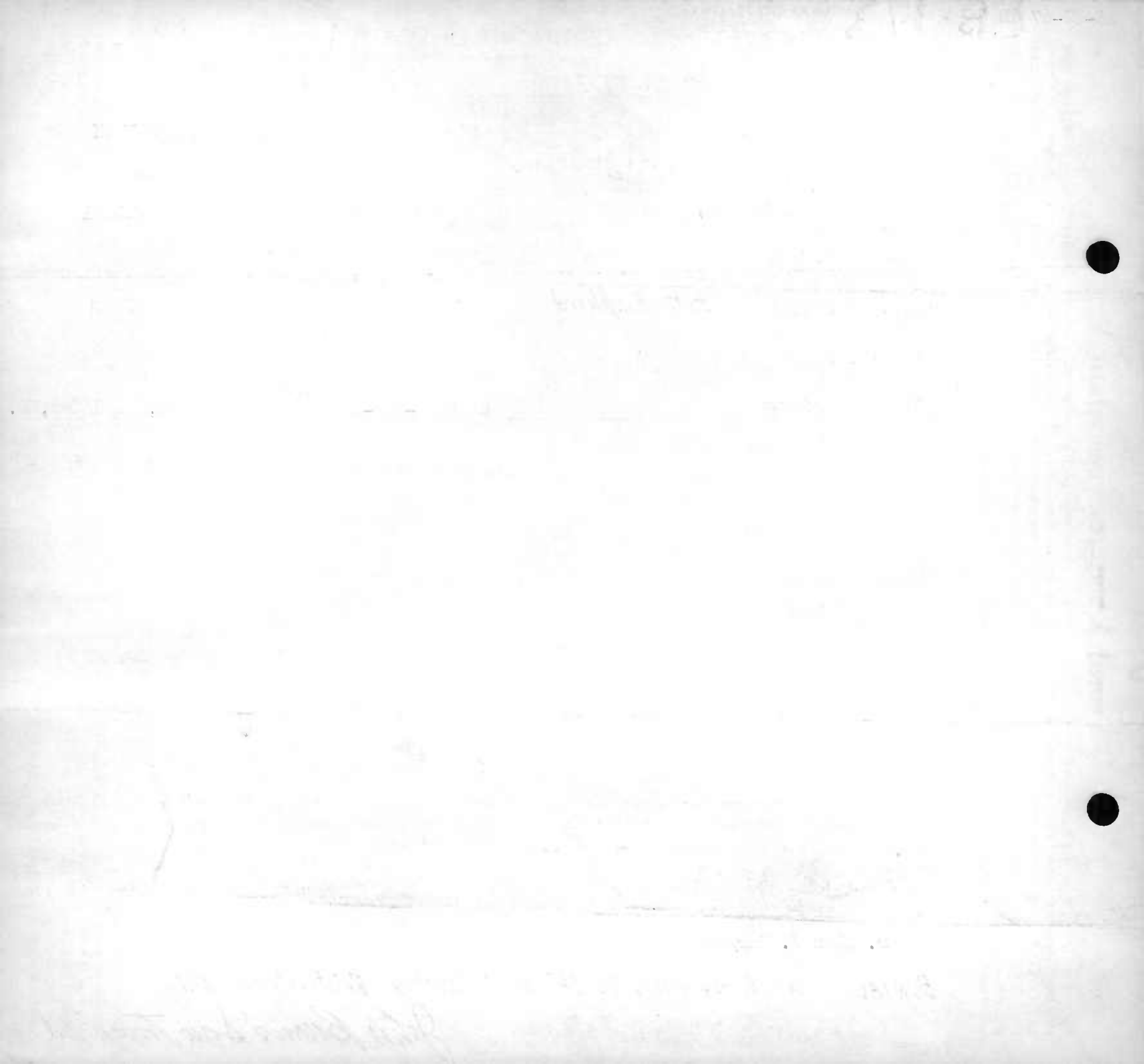
25C. FUNERAL DIRECTOR

John Barnes' Sons, Towson, Md.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12615 | |
|---|------------------|--|---------------------------------|--|---|
| BIRTH NO. 66 12615 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) WOOD, Catherine | | 2. DATE AND HOUR OF DEATH 12/14/66 8:05 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 MARYLAND General Hosp. | | A. STATE MD. B. COUNTY BALTO. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 739 Regester Ave | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 12/2/03 | 9. AGE (In years last birthday) 63 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY OWN Home | | 11. BIRTHPLACE (State or foreign country) Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME DECEASED | | 14. MOTHER'S MAIDEN NAME DECEASED | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 217-48-8144 | | 17. INFORMANT MARGARET WOOD ADDRESS SAME | |
| 18. 199.2.1 | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO carcinomatosis | | 6 months | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO source - unknown | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (C) _____ | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/22/66 to 12/14/66 , that (I) (we) lost saw the deceased alive on 12/14/66 and that in (my) four opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Daniel E. Wilkerson M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/14/66 | | | |
| 23C. PHYSICIAN'S NAME (Type) Daniel E. Wilkerson M.D. | | 23D. ADDRESS 721 Regester Ave. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE DEC. 15, 1966 | | 24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Parkville, Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 19 1966 | | 25B. NAME OF REGISTRAR Robert E. Tabor, M.D. | | 25C. FUNERAL DIRECTOR John Burns' Son, Towson, Md. ADDRESS | |

1
A-523

66 12616

BALTIMORE CITY HEALTH DEPARTMENT

66 12616

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

PAUL C. ANKEWITZ

2. DATE AND HOUR PRONOUNCED DEAD

December 15, 1966 9:40 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 3312 Tate Street

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3312 Tate Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

S.

8. DATE OF BIRTH

2/27/47

9. AGE (In years last birthday)

19

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

SUR. Eng.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Ind.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

August

14. MOTHER'S MAIDEN NAME

HENRIETTA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Yes

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Family - Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Pulmonary Emphysema.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK

NOT WHILE AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE
EXAMINER'S NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED
12/15/66

23A. BURIAL, CREMATION, REMOVAL (Specify)

23B. DATE

12/19/66

23C. NAME OF CEMETERY or CREMATORY

Louisa Park

23D. LOCATION

(City, town, or county)

(State)

Baltimore

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

DEC 19 1966

Robert E. Taylor, M.D.

McCurry - 237

Parapase

WALLLEY BOINGE
WALLLEY BOINGE
WALLLEY BOINGE

66 12617

BALTIMORE CITY HEALTH DEPARTMENT

66 12617

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HENRY C. MUTH

2. DATE AND HOUR PRONOUNCED DEAD

December 16, 1966 3:00 P

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

37 Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3401 Elliott Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Oct. 14, 1903

9. AGE (In years
last birthday)

63

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Self Employed

10B. KIND OF BUSINESS OR INDUSTRY

Confectionary Store

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Frederick Muth

14. MOTHER'S MAIDEN NAME

Mary Herman

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

9-27-19

9-18, 1928

16. SOCIAL
SECURITY NO.

216-03-5893

17. INFORMANT

Mrs. Mildred E. Muth

ADDRESS

3401 Elliott Street

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/17/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Dec. 20, 1966 Oak Lawn

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

Baltimore, County, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

DEC 19 1966

Robert E. Falcetta

Lilly & Zeiler Inc. 1901-07 Eastern Ave.

WALKLEY FOLIO
UNEXPOSED

[Faint, illegible text and markings covering the page]

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 12618 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12618 | |
|---|-------------------------|--|--|---|--|---|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Edith E. Harthausen</i> | | | | 2. DATE AND HOUR OF DEATH <i>12/18/66</i> <i>2 P. M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>43 Se. Balto. Gen. Hosp.</i> | | | | A. STATE <i>md</i> B. COUNTY <i>Baltimore</i> | | | |
| (If not in hospital or institution, give street address or location) | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>25-43</i> | | | |
| D. STREET ADDRESS (If rural, give location) <i>2106 Mail St.</i> | | | | | | | |
| 5. SEX <i>Female</i> | 6. RACE <i>white</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i> | 8. DATE OF BIRTH <i>6/21/1891</i> | 9. AGE (in years last birthday) <i>75</i> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY <i>at home</i> | | 11. BIRTHPLACE (State or foreign country) <i>md</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i> |
| 13. FATHER'S NAME <i>Samuel Riley</i> | | | 14. MOTHER'S MAIDEN NAME <i>Catherine Zimmerman</i> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | | 16. SOCIAL SECURITY NO. <i>-</i> | | 17. INFORMANT <i>Mr John D. Harthausen</i> | | |
| 18. <i>332 XI</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Cerebral Arteriosclerosis with encephalomalacia</i> | | | CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH <i>12 months</i> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION first. | | | (A) DUE TO | | | | |
| | | | (B) DUE TO | | | | |
| | | | (C) DUE TO | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>no</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>10 24</i> 19 <i>66</i> to <i>12/18</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>12/16</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>John P. Urlock Jr</i> | | | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) <i>JOHN P. URLOCK JR</i> | | | | | | 23D. ADDRESS <i>1227 Warrington Blvd</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12/21/66</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Cedar Hill Cem.</i> | | 24D. LOCATION (City, town, or county) (State) <i>Ritchie Hwy Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR <i>John J. Chowansky</i> | | 25C. FUNERAL DIRECTOR <i>John J. Chowansky</i> | | ADDRESS <i>23. md</i> | |

12-11-1911
12-11-1911

12-11-1911

12-11-1911

12-11-1911

12-11-1911

12-11-1911

12-11-1911

66 12619

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12619

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)ANNA *M* BISHOP

2. DATE AND HOUR PRONOUNCED DEAD

December 18, 1966 6:31 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

43 South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

779 Carroll Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

3/17/1914

9. AGE (In years
last birthday)

52

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

at Home

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Dominic Pusinsky

14. MOTHER'S MAIDEN NAME

Ann Jurglis

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

No

17. INFORMANT

Mr. Joseph W. Pusinsky

ADDRESS

830 W. Lombard

18.

443X1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic and Hypertensive

DOES NOT

Heart Disease.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/18/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/21/66

23C. NAME of CEMETERY or CREMATORY

Forestlawn Cem.

23D. LOCATION

Baltimore National Pike

(City, town, or county)

901 St.

(State)

23rd Md.

24A. DATE REC'D BY HEALTH DEPT.

DEC 19 1966

24B. NAME OF REGISTRAR

Robert E. Fabel

24C. FUNERAL DIRECTOR

John J. Cowanson Inc.

ADDRESS

901 St.

WALBURN FORD

2004/10/10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|
| 66 12620 | | | | | Registered No. 66 12620 | | | | |
| BIRTH NO. 66 12620 | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | | 2. DATE AND HOUR OF DEATH | | | | |
| Isadore T. Posner | | | | | December 14, 1966 1 3.25 P. M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| Sinai Hospital | | | | | Maryland | | | | |
| 17. INFORMANT | | | | | ADDRESS | | | | |
| Philip Posner | | | | | Mrs. Bessie Posner, 4002 Emmart Avenue | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. | | | | |
| No | | | | | 213-14-4941 | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | CAUSE OF DEATH | | | | |
| (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) | | | | | (A) DUE TO | | | | |
| (B) DUE TO | | | | | (C) DUE TO | | | | |
| Anterior wall Heart Attack | | | | | Coronary thrombosis | | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| II | | | | | 15 yrs | | | | |
| 19A. DATE OF OPERATION | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | |
| D | | | | | 20A. AUTOPSY? (Yes or No) | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | 21D. TIME OF INJURY (APPROX.) | | | | |
| 21E. INJURY OCCURRED | | | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1956 to 12/14/66 that (I) (we) last saw the deceased alive on 12/14/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | 23A. SIGNATURE | | | | |
| Dr. Joseph Shear | | | | | 23B. DATE SIGNED | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | 23D. ADDRESS | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | | 24B. DATE | | | | |
| Burial | | | | | 12/16/66 | | | | |
| 24C. NAME OF CEMETERY or CREMATORY | | | | | 24D. LOCATION (City, town, or county) (State) | | | | |
| Shaarei Tfiloh | | | | | Baltimore, Maryland | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | | 25B. NAME OF REGISTRAR | | | | |
| DEC 19 1966 | | | | | Sol Levinson & Bros. Inc., 6010 Reisterstown | | | | |



30-69-62

150

66 12621

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66 12621

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Hilda WAUGHN

2. DATE AND HOUR OF DEATH

12-14-66

6:35 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 212244. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

221 S. Washington Street 21231

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Separated

8. DATE OF BIRTH

3-10-1920

9. AGE (In years
lost birthday)

46

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Max Stone

14. MOTHER'S MAIDEN NAME

Hannah Steinbach

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

Unknown

17. INFORMANT

ADDRESS

RECORDS: BCH 4940 Eastern Avenue 21224

1B.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(A) Lannaec's Cirrhosis
DUE TO

6 years

(B) Chronic Alcoholism
DUE TO

over 10 years

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (nately medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
WorkNot While
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (the hospital) attended the deceased from 12-12 1966 to 12-14- 1966,
that (I) (we) lost saw the deceased alive on 12-14 19 66 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

David J. Mishelovich

M.D.

Attending
Phys.Med.
DirectorStaff
Phys.

23B. DATE SIGNED

12-14-66

23C. PHYSICIAN'S
NAME (Type)

David Mishelovich

M.D.

23D. ADDRESS

4940 Eastern Avenue Baltimore, Maryland 21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

12/16/66

24C. NAME of CEMETERY or CREMATORY

Oheb Shalom

24D. LOCATION

Baltimore, Maryland

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 18 1966

25B. NAME OF REGISTRAR

Sol E. Feldman

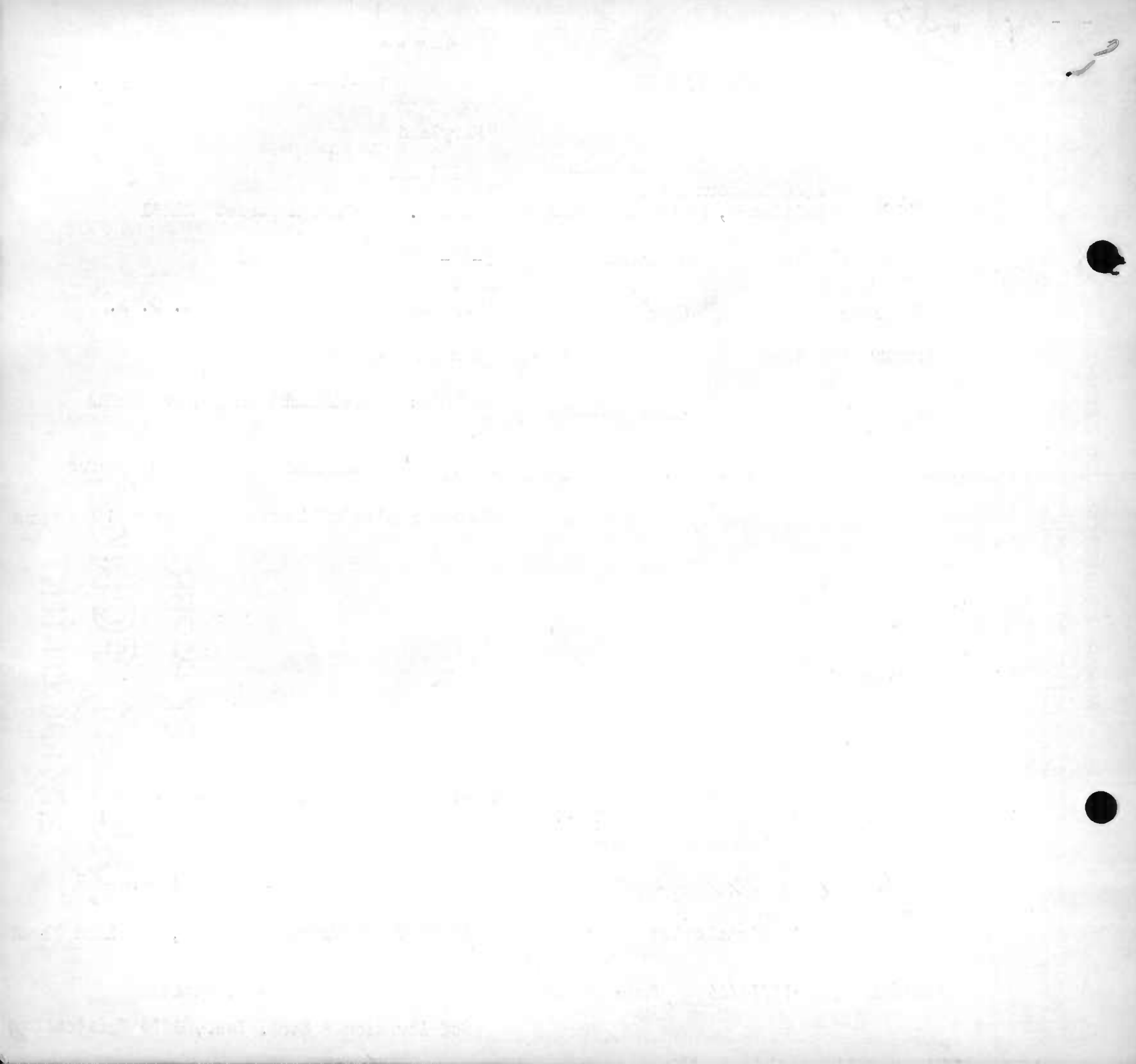
25C. FUNERAL DIRECTOR

Sol Levinson & Bros. Inc., 6010 Reisterstown

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



| BIRTH NO. 66 12622 | | BALTIMORE CITY HEALTH DEPARTMENT | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12622 | |
|---|---------------|---|---------------------|--|--|
| M.E. CASE NO. F-635 | | 1. NAME OF DECEASED (Type or Print) JOSEPH FRIEDMAN | | 2. DATE AND HOUR PRONOUNCED DEAD November 30, 1966 8:50 A M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland | | B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4350 Park Heights Avenue | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-13 | | D. STREET ADDRESS (If rural, give location) 4350 Park Heights Avenue | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never Married | 8. DATE OF BIRTH 60 | 9. AGE (In years last birthday) 60 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman | | 10B. KIND OF BUSINESS OR INDUSTRY Clothing | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT Hebrew Free Burial Society ADDRESS | |
| 18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | Arteriosclerotic Cardiovascular Disease. | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) DUE TO | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (C) DUE TO | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Petty | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 11/30/66 | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 12/16/66 | | 23C. NAME of CEMETERY or CREMATORY Oheb Shalom | |
| 23D. LOCATION (City, town, or county) Baltimore, Maryland | | 23E. NAME of REGISTRAR Robert E. Fisher, M.D. | | 23F. FUNERAL DIRECTOR ADDRESS Sol Levinson & Bros. Inc., 6010 Reisterstown | |

2

WALTON E. JONES

WALTON E. JONES

WALTON E. JONES

WALTON E. JONES

WALTON E. JONES

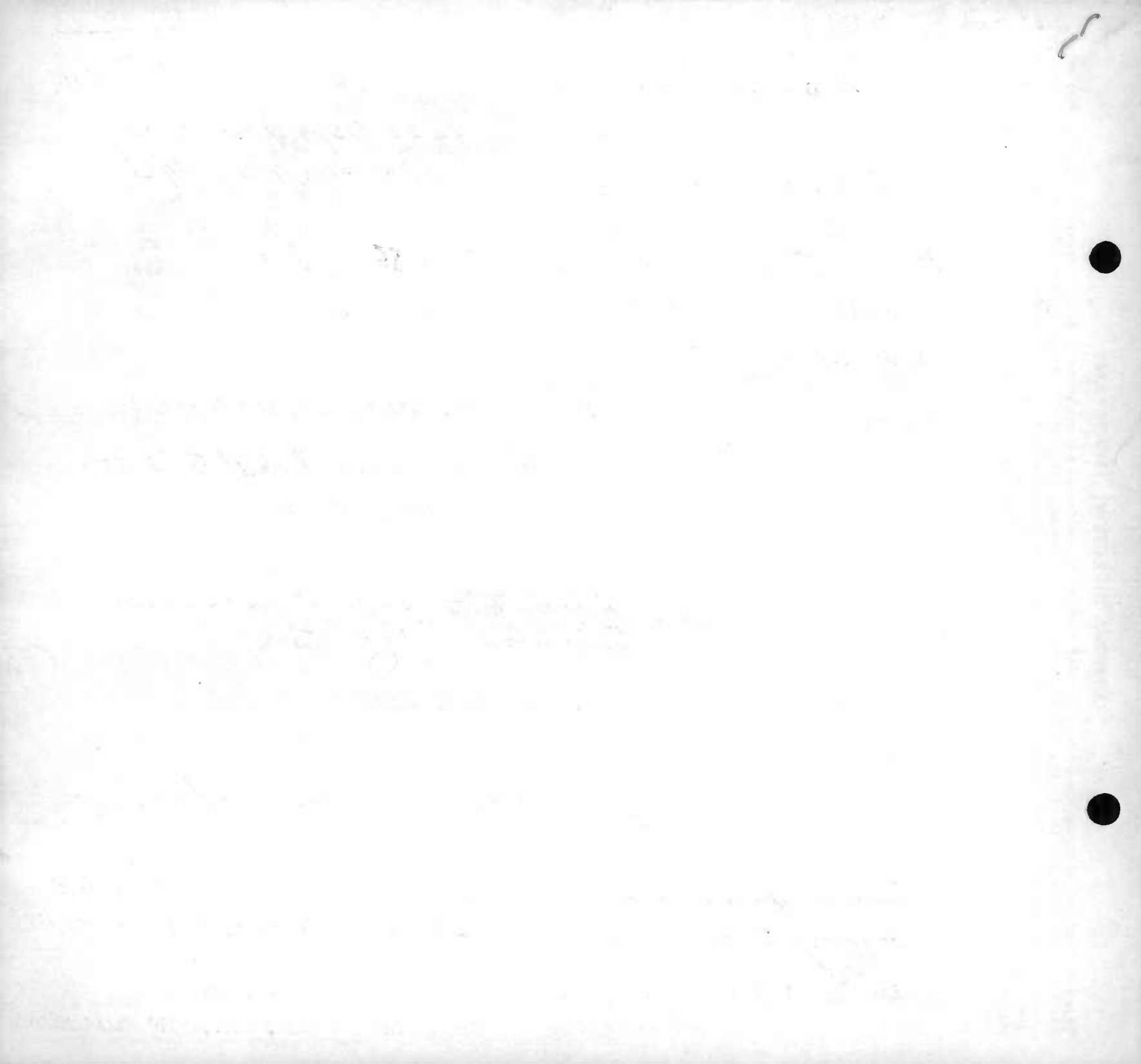
WALTON E. JONES

WALTON E. JONES

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

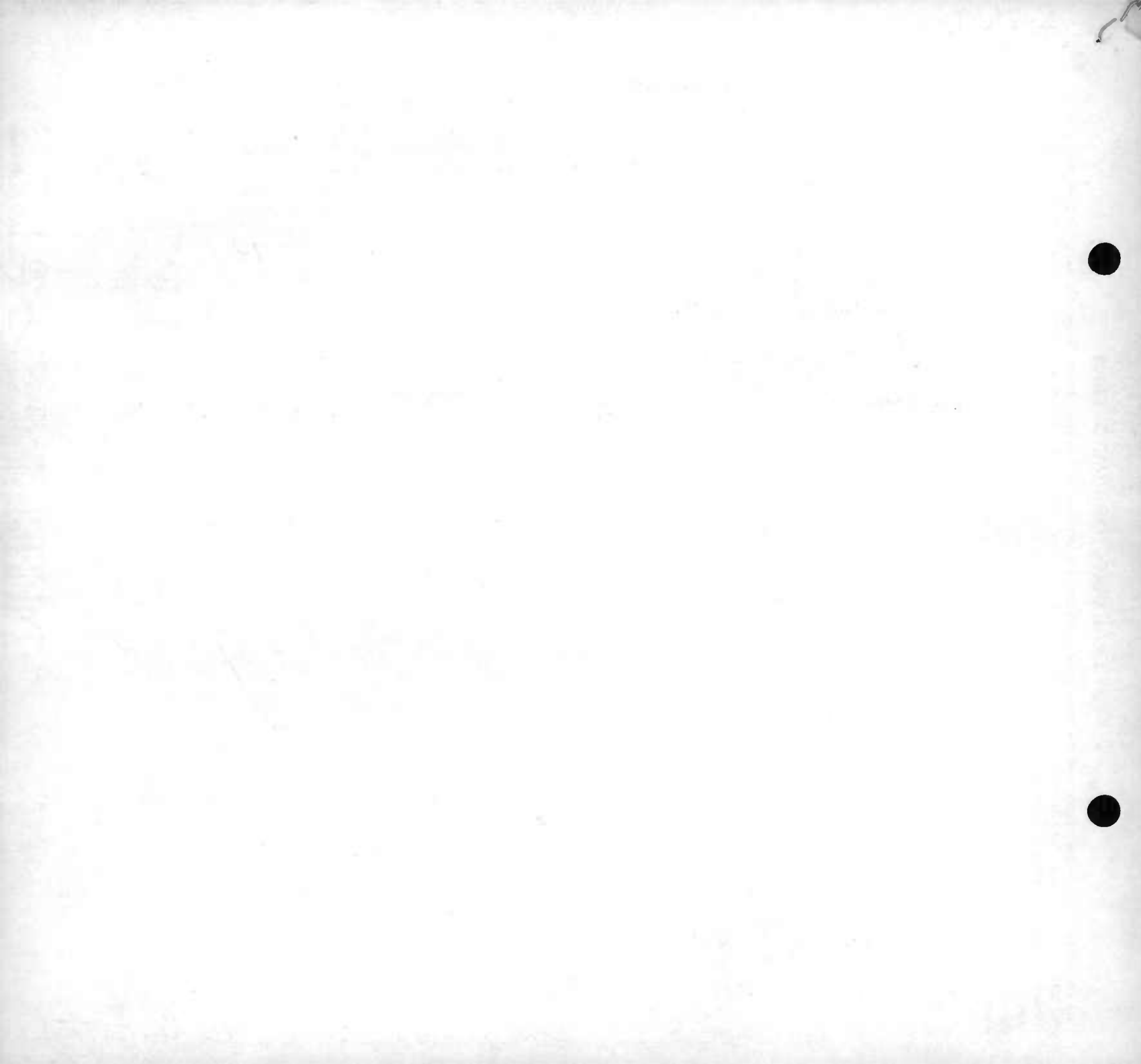
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12623 | |
|--|---------------------|---|------------------------------------|--|--|
| <div style="display: flex; justify-content: space-between;"> M1253 66 12623 CERTIFICATE OF DEATH </div> | | | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Moshontz</i> | | 2. DATE AND HOUR OF DEATH <i>12/15/66 11:35 AM</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <i>425 Sinai Hospital</i> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore, Md</i> D. STREET ADDRESS (If rural, give location) <i>3421 Olympia Ave 27-20</i> | | | |
| 5. SEX <i>F</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i> | 8. DATE OF BIRTH <i>3/13/80</i> | 9. AGE (In years lost birthday) <i>86</i> | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>At Home</i> | | 11. BIRTHPLACE (State or foreign country) <i>Leeds, England</i> | |
| 13. FATHER'S NAME <i>Louis Benjamin</i> | | 14. MOTHER'S MAIDEN NAME <i>Leah ?</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>No</i> | | 17. INFORMANT <i>Mr. Bert Lichtig, 3421 Olympia Avenue</i> | |
| 18. <i>578X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Acute Gastro-Enteritis / 2 hr</i> <i>Hemorrhage</i> | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Arteriosclerotic Cardiovascular Disease</i> <i>Diabetes Mellitus</i> | | | | | |
| 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>12/11/66</i> to <i>12/15/66</i> 19 <i>66</i> that (I) (we) last saw the deceased alive on <i>12/15/66</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <input checked="" type="checkbox"/> (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Harvey S. Fourerman</i> | | | | 23B. DATE SIGNED <i>12/15/66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Harvey S. Fourerman</i> | | 23D. ADDRESS <i>6210 Park Heights Ave Balt 2825</i> | | | |
| 24A. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12/16/66</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>New Har Sinai</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR <i>Sol Levinson & Bros. Inc., 6010 Reisterstown</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | Registered No. <u>318075</u> | |
|---|---|--|--|--|---|
| BIRTH NO. <u>66 12624</u> | | CERTIFICATE OF DEATH | | 66 12624 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>SAK, ZDZISLAW</u> | | 2. DATE AND HOUR OF DEATH <u>12.16.66 - 1:35AM</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>42</u> <u>SINAI HOSPITAL OF BALTIMORE</u> <u>BELVEDERE AT GREENSPRING</u> | | A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> <u>27-17</u> | | | |
| | | D. STREET ADDRESS (If rural, give location) <u>2716 OAKLEY AVE</u> | | | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>4-2-92</u> | 9. AGE (In years lost birthday) <u>74</u> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Retail Grocery</u> | | 11. BIRTHPLACE (State or foreign country) <u>Poland</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> |
| 13. FATHER'S NAME <u>Solomon Sak</u> | | | 14. MOTHER'S MAIDEN NAME <u>Ida ?</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | 17. INFORMANT <u>Mrs. Eva Sak, 2716 Oakley Avenue</u> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Cn Pulmonale</u> | | CAUSE OF DEATH (A) DUE TO <u>Pulmonary Emphysema</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>—</u> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> | | (B) DUE TO | | | |
| (C) | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u> | 20A. AUTOPSY? (Yes or No) <u>no</u> | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>—</u> | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u> | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u> | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>—</u> | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? <u>—</u> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>11-3-1966</u> to <u>12-16-1966</u> , that (I) (we) lost saw the deceased alive on <u>12-16-1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Lucille E. Venturanza</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED <u>12-16-66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>LUCILLE E. VENTURANZA</u> M.D. | | | 23D. ADDRESS <u>Sinai Hospital of Baltimore</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | 24B. DATE <u>Dec 16/66</u> | 24C. NAME OF CEMETERY or CREMATORY <u>Chen-Chava Chased</u> | 24D. LOCATION (City, town, or county) (State) <u>Randallstown, Md</u> | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 19 1966</u> | 25B. NAME OF REGISTRAR <u>Dr. E. Tarkenton</u> | 25C. FUNERAL DIRECTOR <u>Mr. J. J. J. J.</u> | ADDRESS <u>2nd - 6010 Ruston Road</u> | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--|--|--|---|--|
| BIRTH NO. 66 12625 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12625 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Frances Kohn</i> | | 2. DATE AND HOUR OF DEATH <i>December 15, 1966</i> 6:30 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | 5. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>4221 Pimlico Road</i> | | A. STATE <i>Maryland</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> 15-13 | |
| D. STREET ADDRESS (If rural, give location) <i>4221 Pimlico Road</i> | | 6. DATE OF BIRTH <i>Jan. 25, 1892</i> | | 7. AGE (In years last birthday) <i>73</i> | |
| 5. SEX <i>Female</i> | | 6. RACE <i>White</i> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Single</i> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Seamstress</i> | | 11. BIRTHPLACE (State or foreign country) <i>Russia</i> | |
| 13. FATHER'S NAME <i>Abraham Kohn</i> | | 14. MOTHER'S MAIDEN NAME <i>Celia</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>212-07-2357</i> | | 17. INFORMANT <i>Mrs. Marie Kohn - 4221 Pimlico Rd</i> | |
| 18. <i>180X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) <i>Circumvented Kidney in Metastatic Cancer</i> DUE TO (B) _____ DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH <i>8 months</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>8</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>1966</i> 19 to <i>17/5/66</i> 19 that (I) (we) last saw the deceased alive on <i>17/5</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Milton B. Kresh</i> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>17/5/66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>MILTON B. KRESH</i> | | 23D. ADDRESS <i>4000 W. NORTHERN PKWY.</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>Dec 16/66</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Mike's Kodesh B'd Chas</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 16 1966</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Taylor</i> | |
| 25C. FUNERAL DIRECTOR <i>Sol Leunson</i> | | 25D. ADDRESS <i>212</i> | | 25E. ADDRESS <i>6010 Reat Road</i> | |

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[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

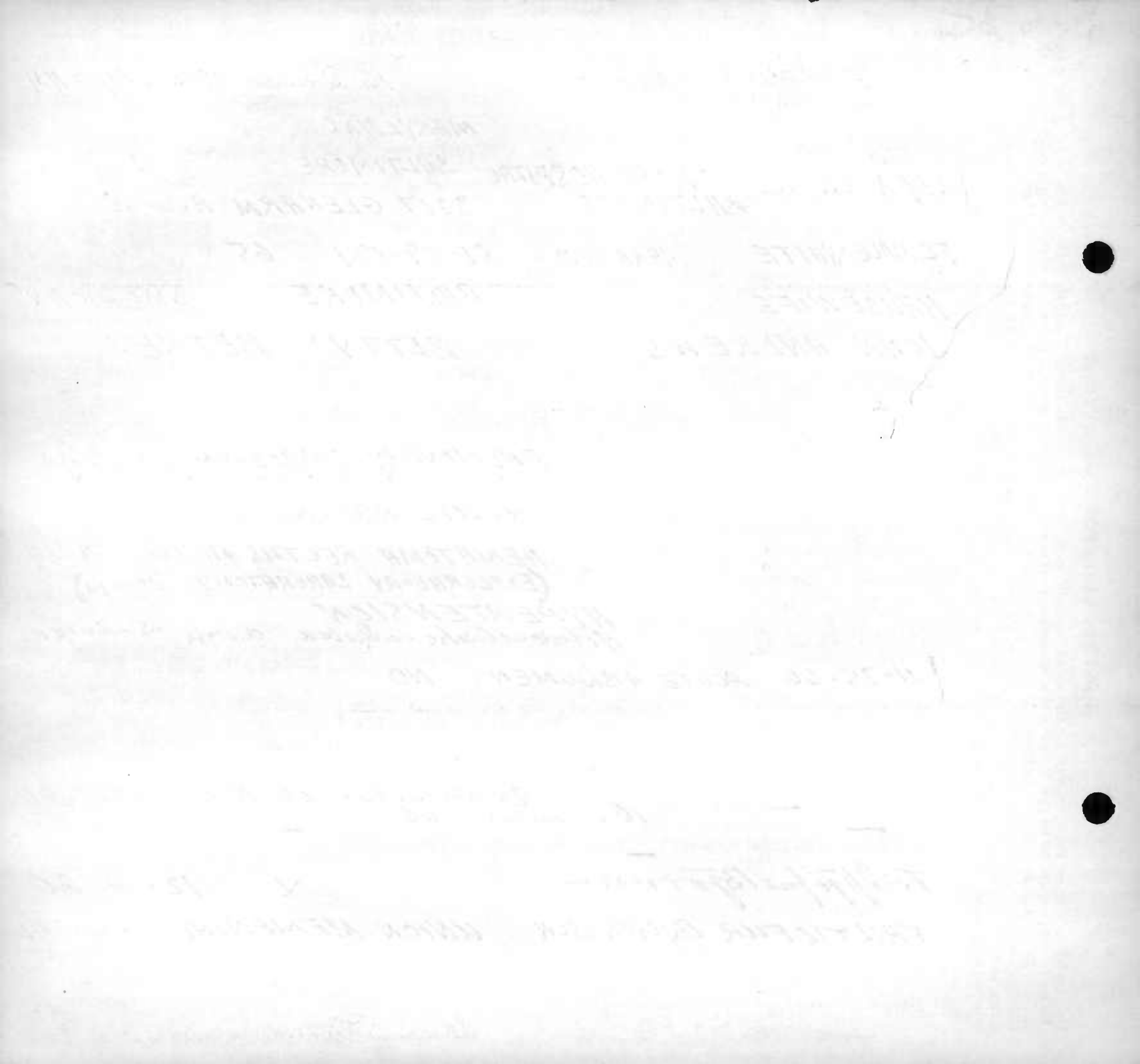
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|------------------|---|--|---|---|---|--|----------------------------------|--|
| BIRTH NO. 66 12626 | | | | | CERTIFICATE OF DEATH | | Registered No. 374 673 | | |
| 1. NAME OF DECEASED (Type or Print) ESTHER SILVER MAN | | | | | 2. DATE AND HOUR OF DEATH 12/15/66 7:30 PM M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital | | | | | A. STATE Maryland B. COUNTY 28-41 | | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) 4401, Groveland Ave | | | | | D. STREET ADDRESS (If rural, give location) Baltimore | | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NOT MARRIED | 8. DATE OF BIRTH 4/1/09 | 9. AGE (In years last birthday) 57 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee | | | 10B. KIND OF BUSINESS OR INDUSTRY Clothing Factory | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME Isaac Silverman | | | 14. MOTHER'S MAIDEN NAME Betsy Fisher | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 212-03-2398 | | | 16. SOCIAL SECURITY NO. 212-03-2398 | | 17. INFORMANT Mr. Simon Cohen - 6978 | | ADDRESS Mrs. Sue Fine | | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES | | | | | (A) Cerebrovascular Accident | | | Approx. 24 hrs. | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (B) Uraemia | | | | |
| | | | | | (C) Antenatal myocardial infarction | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | Ruptured Appendix = peritonitis | | | | |
| 19A. DATE OF OPERATION 1/1/67 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured Appendix | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/11/66 to 12/15/66 , that (I) (we) last saw the deceased alive on 12/15/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE A. J. Ready M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | | 23B. DATE SIGNED 12/15/66 | | | | |
| 23C. PHYSICIAN'S NAME (Type) A. J. Ready M.D. | | | | | 23D. ADDRESS Sinai | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/16/66 | | 24C. NAME of CEMETERY or CREMATORY Morse Monticore | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 19 1966 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Sal Leunon - 6010 | | ADDRESS 2nd St. La | | | |

Date of operation: 12/11/56
Information received via phone from
Linnai Hospital re.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

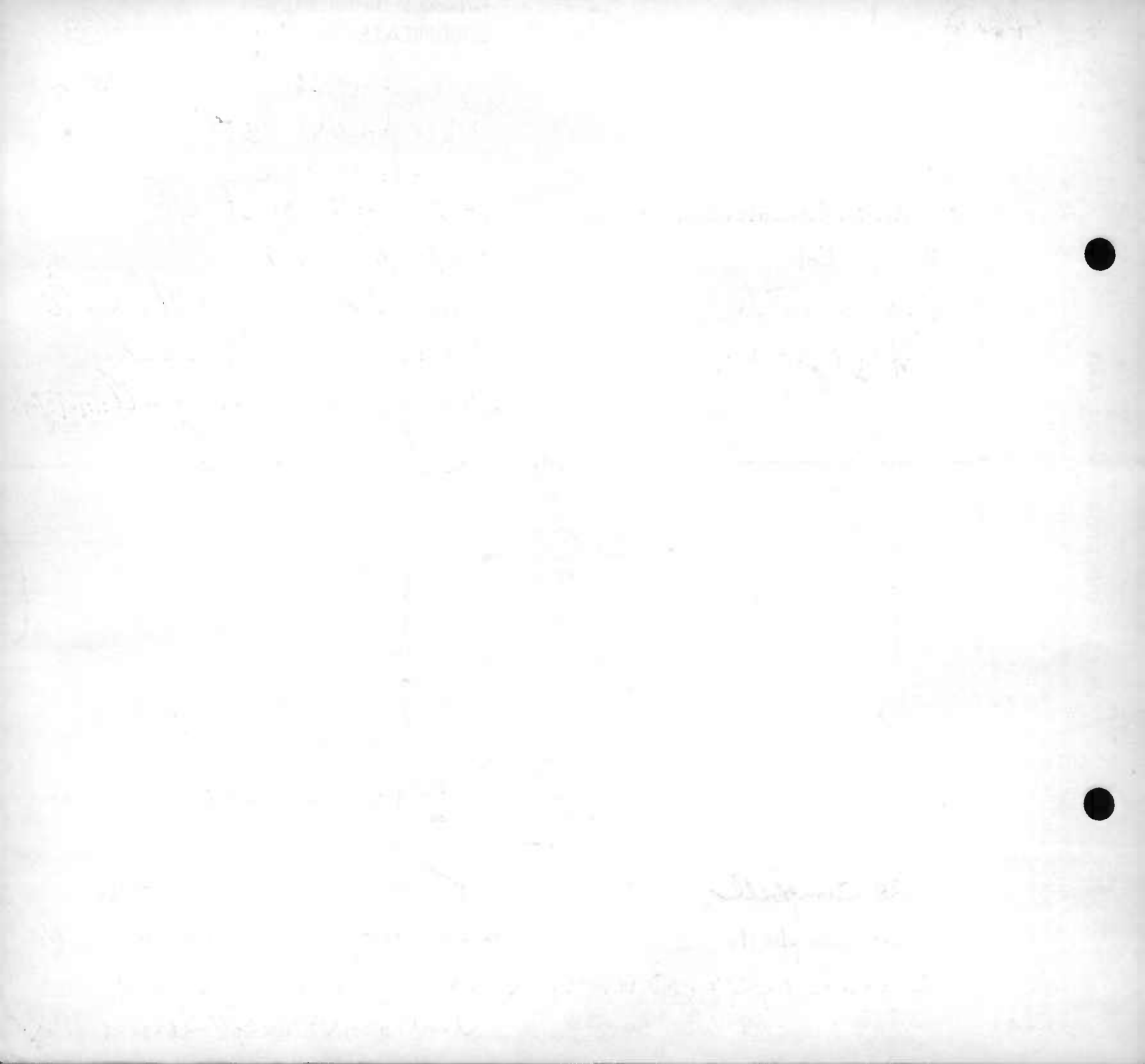
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|---|-------------------------|--|---------------------------------------|---|---|
| BIRTH NO. 66 12627 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12627 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) FREEDY FANNIE F | | 2. DATE AND HOUR OF DEATH 16. December 1966 at 4:40 AM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL BALTIMORE | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 27-44 D. STREET ADDRESS (If rural, give location) 3617 GLENARM AVENUE 212 | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 01-09-1901 | 9. AGE (In years lost birthday) 65 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) BALTIMORE | |
| 12. CITIZEN OF WHAT COUNTRY? AMERICAN | | 13. FATHER'S NAME JOHN ANDREWS | | 14. MOTHER'S MAIDEN NAME BETTY BETKEY | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 212-36-7881E | | 17. INFORMANT ADDRESS Mr Raymond Freedy 3617 Glen Arm Avenue 06 | |
| 18. 785, 31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) PULMONARY EMBOLISM DUE TO (B) ACUTE ABDOMEN DUE TO (C) HEMATOMA RECTUS MUSCLE (EXPLORATORY LARORATORY 21days) | | INTERVAL BETWEEN ONSET AND DEATH 18 days 21 days 21days | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. HYPERTENSION Arteriosclerotic cardiovascular disease | | 19A. DATE OF OPERATION 11-25-66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ACUTE ABDOMEN | |
| 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 25 November 19 66 to 16 December 19 66 , that (I) (we) lost saw the deceased olive on 16 December 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Fridtjofur Bjornsson M.D. | | | | 23B. DATE SIGNED 12-16 66 | |
| 23C. PHYSICIAN'S NAME (Type) FRIDTJOFUR BJORNSSON M.D. | | | | 23D. ADDRESS UNION MEMORIAL HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-19-66 | | 24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore Md. | | 25A. DATE REC'D BY HEALTH DEPT. | | | |
| 25B. NAME OF REGISTRAR DEC 19 1966 | | 25C. FUNERAL DIRECTOR ADDRESS Lassahn Funeral Home 7401 Belair Road | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---|------------------------|--|--------------------------------------|--|---|
| BIRTH NO. 66 12628 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12628 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <i>Ethel Clark</i> | | | | <i>12-17-66 110:25 A. M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>90 Bat-Wil-Ba Convalescent Home</i> | | A. STATE <i>Maryland</i> B. COUNTY <i>A.A. Co.</i> | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Annapolis 32-10</i> | | | |
| | | D. STREET ADDRESS (If rural, give location) <i>37 North Street St.</i> | | | |
| 5. SEX <i>F.</i> | 6. RACE <i>Col.</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH <i>9/17/1900</i> | 9. AGE (In years lost birthday) <i>66</i> | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | |
| 13. FATHER'S NAME <i>Unknown</i> | | 14. MOTHER'S MAIDEN NAME <i>Frances Murray</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>George Stephurey - Ann. Md.</i> | |
| | | | | ADDRESS | |
| 18. <i>422.11</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH (A) <i>Arteriosclerotic c.v.d.</i> DUE TO (B) _____ DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>5-19-1963</i> to <i>12-17-1966</i> , that (I) (we) last saw the deceased alive on <i>12-14-1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>C.R. Campbell,</i> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>12-17-66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>C.R. Campbell,</i> | | 23D. ADDRESS M.D. <i>1618 W. North Ave. Baltimore, Md.</i> | | | |
| 24A. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12/21/66</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Brewer Hill</i> | |
| 24D. LOCATION (City, town, or county) <i>Annapolis, Md.</i> | | 24E. STATE <i>Md.</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 19 1966</i> | | 25B. NAME OF REGISTRAR <i>W. E. Talley</i> | | 25C. FUNERAL DIRECTOR <i>William Sekse, II - Anne, Md.</i> | |
| | | | | ADDRESS | |



BIRTH NO. 66 12629

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12629

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

GEORGE

JOHNSON

2. DATE AND HOUR PRONOUNCED DEAD

December 14, 1966

3:35 P

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

39 Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

535 Gold Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

7-1-1921

9. AGE (In years
last birthday)

45

10. If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY

U.S.A.

13. FATHER'S NAME

Fredie Johnson

14. MOTHER'S MAIDEN NAME

Louise Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Lillian Johnson, Arnold

18. 3-25-X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Cor Pulmonale
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Chronic Pneumonitis, Inactive Pulmonary

XXXXXX

Tuberculosis, Partial Left Pneumonectomy.

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

CHIEF MEDICAL EXAMINER ☐

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/15/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12-18-66

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary

23D. LOCATION

(City, town, or county)

(State)

Arnold Md.

24A. DATE REC'D BY HEALTH DEPT.

DEC 19 1966

24B. NAME OF REGISTRAR

Robert E. Talley

24C. FUNERAL DIRECTOR

William Reese

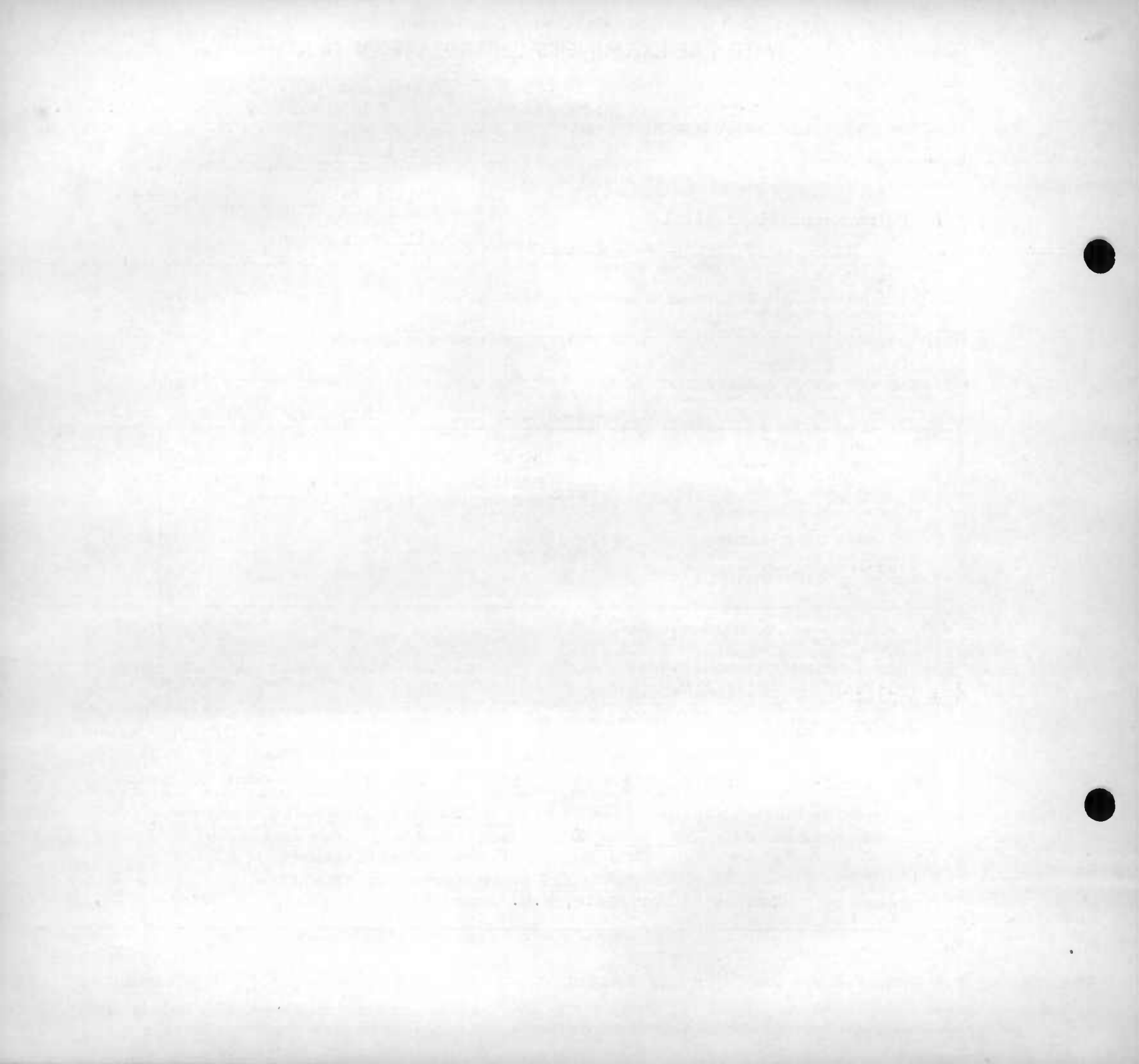
ADDRESS

WALTER BODDIE

100-100-100-100

100-100-100-100

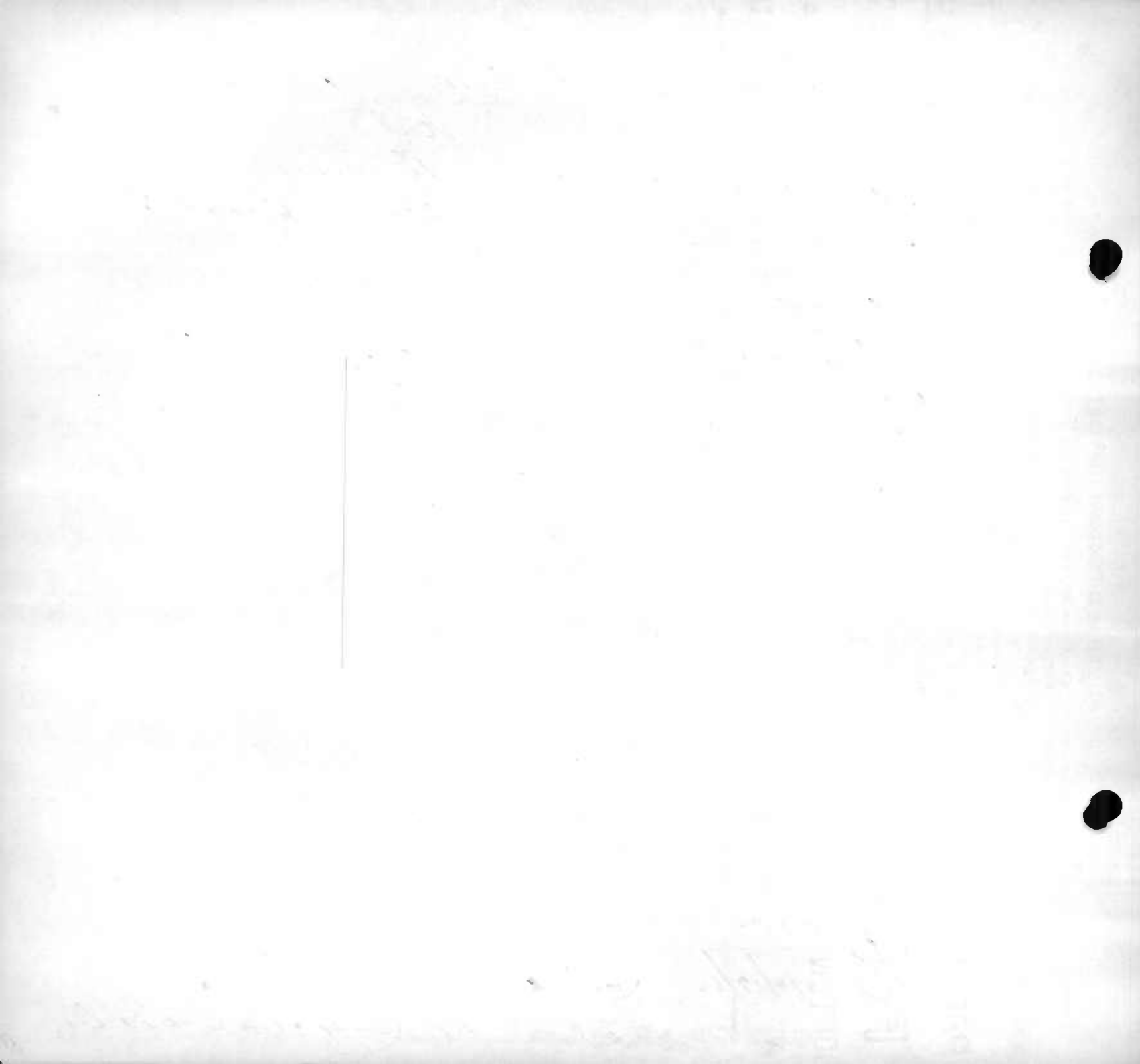
| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | 66 12630 | |
|---|--|--|--|---|--|
| M.E. CASE NO. | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. | | | |
| 1. NAME OF DECEASED (Type or Print) | | LEOTA Mae MC NAMARA | | 2. DATE AND HOUR PRONOUNCED DEAD December 15, 1966 10:20 P. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE Maryland | |
| FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | | B. COUNTY Baltimore | |
| 5. SEX Female | | 6. RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | |
| 8. DATE OF BIRTH March 9, 1898 | | 9. AGE (In years last birthday) 68 | | 10. IF Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Interviewer | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME George Walston | | 14. MOTHER'S MAIDEN NAME Lorena Ford | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 220-09-0268 | | 17. INFORMANT Capt. Lee McNamara | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Blunt injury of abdomen with mesenteric laceration, hemoperitoneum and retroperitoneal hematoma | | CAUSE OF DEATH Blunt injury of abdomen with mesenteric laceration, hemoperitoneum and retroperitoneal hematoma | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) DUE TO | | (C) | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 12-15-66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED abdominal injury | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Belair Road and Glenmore Avenue | |
| 21D. TIME OF INJURY (APPROX.) 12-15-66 4:50 P | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? Driver in auto-auto collision | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED December 16, 1966 | |
| ACTUAL SIGNATURE Charles S. Springate, M.D. | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 12/19/66 | | 23C. NAME of CEMETERY or CREMATORY Parkwood Cemetery | |
| 24A. DATE REC'D BY HEALTH DEPT. DEC 19 1966 | | 24B. NAME OF REGISTRAR J. E. Feltner | | 24C. FUNERAL DIRECTOR Ullrich Funeral Home | |
| 24D. LOCATION (City, town, or county) (State) Parkville, Md. | | 24E. ADDRESS 4210 Belair Road | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 66 12631 | |
|---|------------------|--|----------------------------------|--|----------------------------|--|--|
| BIRTH NO. 66 12631 | | | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Alanna Johnson</i> | | | | 2. DATE AND HOUR OF DEATH <i>12/14/66</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>133 E Birkhead Birkhead</i> | | | | A. STATE <i>Md.</i> | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 24-03</i> | | | |
| | | | | D. STREET ADDRESS (If rural, give location) <i>133 E Birkhead</i> | | | |
| 5. SEX <i>F</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>W</i> | 8. DATE OF BIRTH <i>10/13/94</i> | 9. AGE (In years last birthday) <i>74</i> | If Under 1 Yr. Months Days | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Md.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>Freeman Simmons</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Josephine Watson</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <i>Family - Same</i> | | | |
| 18. <i>450.0</i> CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs.</i> | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | | (A) DUE TO <i>Generalized arteriosclerosis</i> | | | |
| ANTECEDENT CAUSES | | | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Malnutrition</i> | | | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>19 64</i> to <i>Dec. 10</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>Dec. 10</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Romulo V. Goco</i> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED <i>12/15/66</i> | | | |
| 23C. PHYSICIAN'S NAME (Type) <i>Romulo V. Goco</i> M.D. | | | | 23D. ADDRESS <i>5500 Bowleys Lane</i> | | | |
| 24A. BURIAL CREATION, REMOVAL (Specify) <i>B</i> | | 24B. DATE <i>12/17/66</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Cedar Hill</i> | | 24D. LOCATION (City, town, or county) (State) <i>Ba. Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>Dec 18 1966</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Talley</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>McClary - 130 E Fair St.</i> | | | |



1
J-520

66 12632

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12632

BIRTH NO.

M.E. CASE NO.

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) RAYMOND S. JONES | | 2. DATE AND HOUR PRONOUNCED DEAD December 13, 1966 8:20 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 40 St. Agnes Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore Co. C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) RURAL Arbutus 53-00 D. STREET ADDRESS (If rural, give location) 5526 Ashbourne Road | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH May 20, 1913 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Buyer | | 10B. KIND OF BUSINESS OR INDUSTRY Westinghouse | 11. BIRTHPLACE (State or foreign country) Penn. |
| 13. FATHER'S NAME Herman F. Jones | | 14. MOTHER'S MAIDEN NAME Beulah Hunter | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 180-01-8246 | 17. INFORMANT Evelyn Jones 5526 Ashbourne Rd. |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Rheumatic Heart Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II | | | INTERVAL BETWEEN ONSET AND DEATH |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) No |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Rudiger Breiteneker, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/14/66 | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | 23B. DATE 12/17/66 | 23C. NAME of CEMETERY or CREMATORY Landon Park Cemetery | 23D. LOCATION (City, town, or county) (State) Baltimore, Maryland |
| 24A. DATE REC'D BY HEALTH DEPT. | 24B. NAME OF REGISTRAR R. B. E. Jones | 24C. FUNERAL DIRECTOR Ambrose, Inc. 1328 Sulphur Sp Rd. | |

VS 151-REV. 1/1/65

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|--|-------------------------------------|--|---|
| BIRTH NO. 66 12633 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12633 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Edward C. Mullikin | | 2. DATE AND HOUR OF DEATH 13 Dec 1966 4:10 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 26-11 | | | |
| | | D. STREET ADDRESS (If rural, give location) 3322 FOSTER AVENUE 21224 | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 2/15/ 85 | 9. AGE (In years last birthday) 81 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME JAMES T. Mullikin | | 14. MOTHER'S MAIDEN NAME Bertie Mary Ann Larrimore | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 217-09-24701 | | 17. INFORMANT ADDRESS RECORDS: BCH 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Ca. of Rectum | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 7 1/2 Yr. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 13 Dec 1966 to 13 Dec 1966 , that (I) (we) last saw the deceased alive on 13 Dec 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Dudley A. Raine | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 13 Dec 1966 | |
| 23C. PHYSICIAN'S NAME (Type) DR. DUDLEY A. RAINE | | 23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MD. 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/16/1966 Spring Hill | | 24C. NAME OF CEMETERY or CREMATORY Easton, Md. | |
| 24D. LOCATION (City, town, or county) (State) | | 25A. DATE REC'D BY HEALTH DEPT. DEC 10 1966 | | 25B. NAME OF REGISTRAR MAURICE E. NEUNAM & SON, Easton, Md. | |
| 25C. FUNERAL DIRECTOR ADDRESS | | | | | |

R-163

66 12634

BALTIMORE CITY HEALTH DEPARTMENT

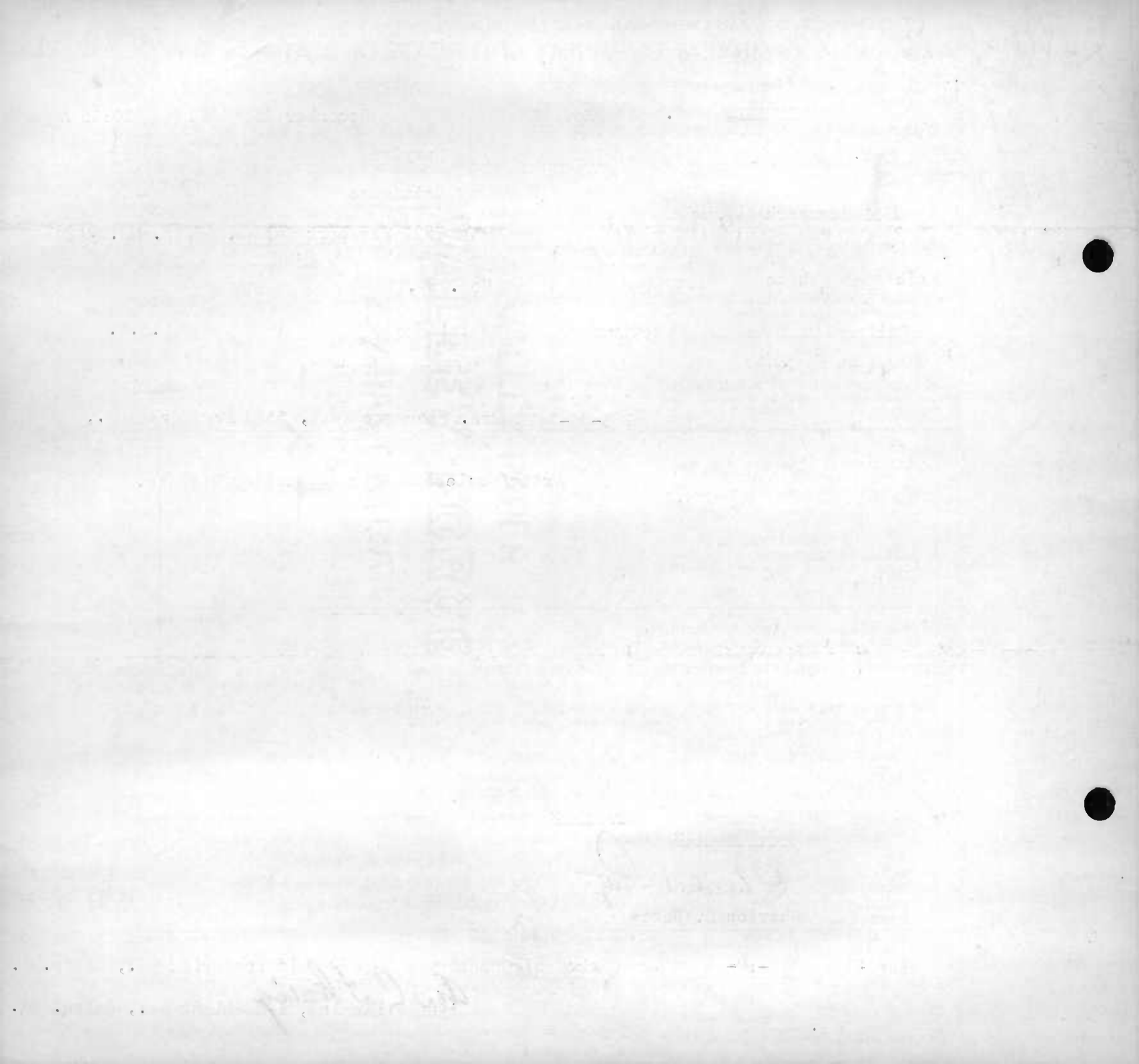
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66 12634

BIRTH NO.

M.E. CASE NO.

| | | | | | |
|---|------------------|--|--|---|--|
| 1. NAME OF DECEASED (Type or Print) RICHARD G. REBBERT | | | 2. DATE AND HOUR PRONOUNCED DEAD December 15, 1966 10:15 A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 5522 Fernpark Avenue 00 | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 28-02 D. STREET ADDRESS (If rural, give location) 5522 Fernpark Avenue, Balto. Md. 21207 | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Widowed | 8. DATE OF BIRTH Nov. 30, 1884 | 9. AGE (In years last birthday) 82 | If Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad | | 10B. KIND OF BUSINESS OR INDUSTRY Retired | | 11. BIRTHPLACE (State or foreign country) Baltimore | |
| 13. FATHER'S NAME Theodore Rebbert | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. 705-05-7470 | | |
| 17. INFORMANT Mrs. Florence Best, 5522 Fernpark Ave., | | | ADDRESS | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 422.1 I Arteriosclerotic Cardiovascular Disease. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIB- UTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Charles S. Petty</i> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Petty M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/15/66 | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 12-19-66 | | 23C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery | |
| 24A. DATE REC'D BY HEALTH DEPT. DEC 10 1966 | | 24B. NAME OF REGISTRAR Robert E. Fiedler | | 24C. FUNERAL DIRECTOR Flynn & Fleming, 1422 Light St., Balto. Md. | |
| 23D. LOCATION (City, town, or county) (State) 4300 Old Frederick Rd., Balto. Md. | | | | | |



TYPED BY: WBB *WBB*
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------------------|---|-------------------------------------|--|---|
| 66-12635 | | CITY OF BALTIMORE HEALTH DEPARTMENT | | Registered No. 66 12635 | |
| BIRTH NO. HARRY E. FISHER, SR. | | | | CERTIFICATE OF DEATH | |
| NAME OF DECEASED (Type or Print) <i>FISHER, HARRY</i> | | 2. DATE AND HOUR OF DEATH <i>12/16/66 1145 A.M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Maryland General Hosp</i> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md</i> B. COUNTY <i>BALTIMORE</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balto, md (Dundalk)</i> D. STREET ADDRESS (If rural, give location) <i>207 Patapsco Ave zone 22</i> | | | |
| 5. SEX <i>M</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>M</i> | 8. DATE OF BIRTH <i>4/3/1884</i> | 9. AGE (In years last birthday) <i>82</i> | 10. Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>BUILDER</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>HOME CONSTR.</i> | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | |
| 13. FATHER'S NAME <i>JOHN FISHER (dec)</i> | | 14. MOTHER'S MAIDEN NAME <i>? Stains</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>218-32-2150</i> | | 17. INFORMANT <i>14 TOWNSHIP Son H.E. FISHER, JR. - DUNDALK 22</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH <i>pulmonary embolus</i> <i>fractured hip</i> <i>urea</i> <i>bowel obstruction - days?</i> <i>Uremia ASCVD - years</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i> | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>home</i> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>same</i> <i>25-04</i> | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <i>Dec 10 '66 12</i> | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? <i>fell in yard</i> | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>12/10</i> 19 <i>66</i> to <i>12/16</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>12/16</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Nicholas C Bosch</i> 23C. PHYSICIAN'S NAME (Type) <i>Nicholas C. Bosch</i> | | | | 23B. DATE SIGNED <i>12/14/66</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 24B. DATE <i>12/19/66</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>OAKLAWN CEMETERY</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>BALTIMORE CO., MD.</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 18 1966</i> | | | |
| 25B. NAME OF REGISTRAR <i>W. E. Fisher</i> | | 25C. FUNERAL DIRECTOR <i>WALTER BROOKS BRADLEY, DUNDALK, MD.</i> | | | |

| 66 12636 | | BALTIMORE CITY HEALTH DEPARTMENT | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12636 | |
|---|---------|--|---|--|--|
| BIRTH NO. | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) | | | 2. DATE AND HOUR PRONOUNCED DEAD | | |
| THOMAS J. FLEMMING | | | December 16, 1966 1:45 A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | A. STATE Maryland | | |
| 42 99 Sinai Hospital (DOA) | | | B. COUNTY Baltimore Co. | | |
| | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | | |
| | | | Reisterstown 53-00 | | |
| D. STREET ADDRESS (If rural, give location) | | | Bond Avenue Route 3, Box 2 | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (in years last birthday) | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| Male | Negro | Married | April 20, 1907 | 59 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Machine Operator | | Arundel Corp. | | Virginia | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| Shelton Flemming | | | Ann Brown | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 213-05-8342 | | Mrs. Viola C. Flemming Reisterstown | |
| 18. CAUSE OF DEATH | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | |
| (A) Hypertensive cardiovascular disease DUE TO | | | | | |
| (B) DUE TO | | | | | |
| (C) DUE TO | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 2 | | | | Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE | | CHIEF MEDICAL EXAMINER | | DATE SIGNED | |
| Charles S. Springate, M.D. | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | December 16, 1966 | |
| EXAMINER'S NAME (Type) | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | | 23C. NAME of CEMETERY or CREMATORY | |
| Burial | | 12/18/66 | | Mt. Pleasant Cemetery | |
| | | | | Baltimore, Maryland | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | | 24C. FUNERAL DIRECTOR ADDRESS | |
| DEC 18 1966 | | Robert E. Faldut | | H. J. Schuchardt Owings Mills, Md. | |

UNITED STATES
DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

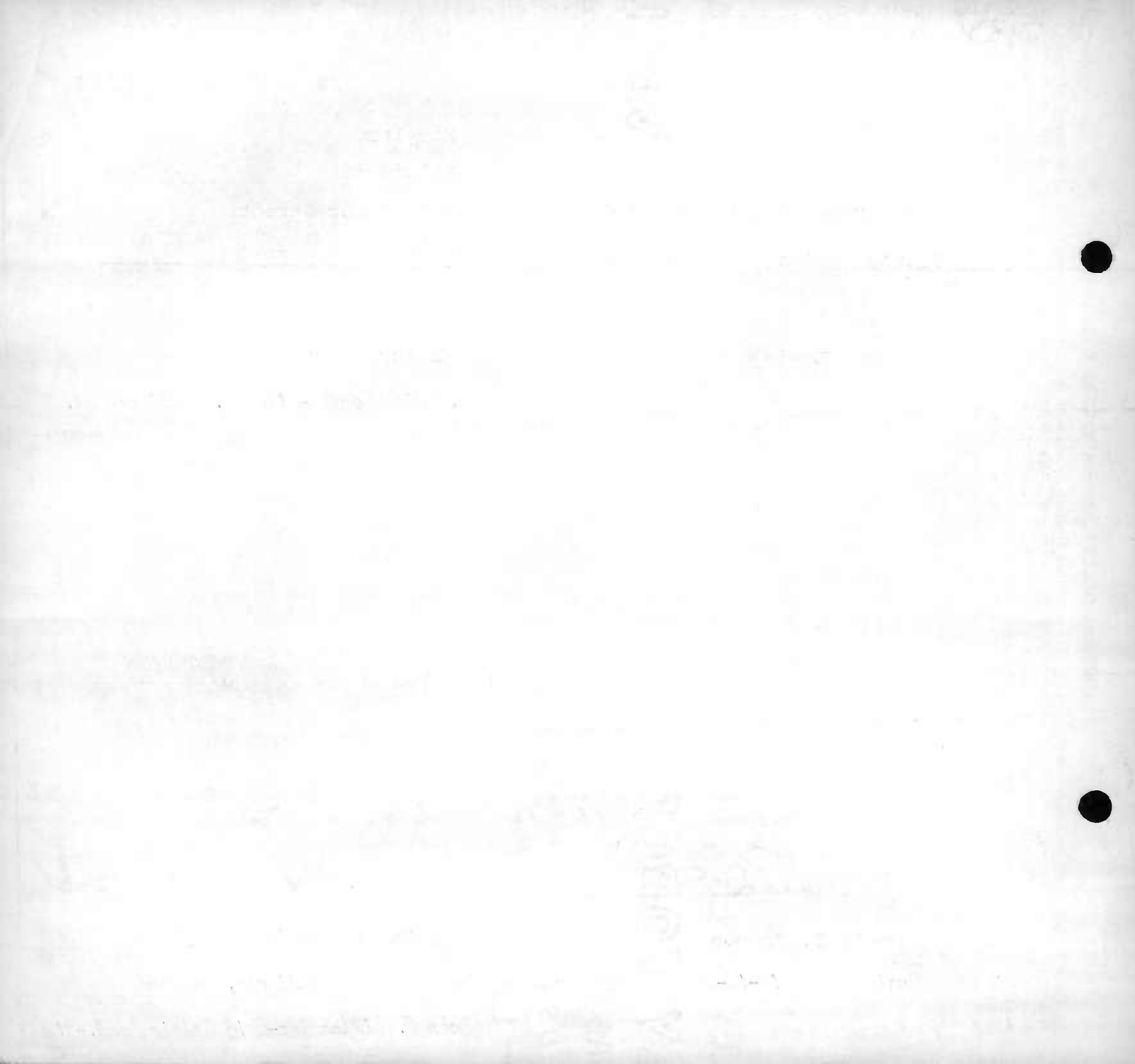
WASHINGTON, D. C. 20535

4-100-104

FUNERAL DIRECTOR: IMPORTANT

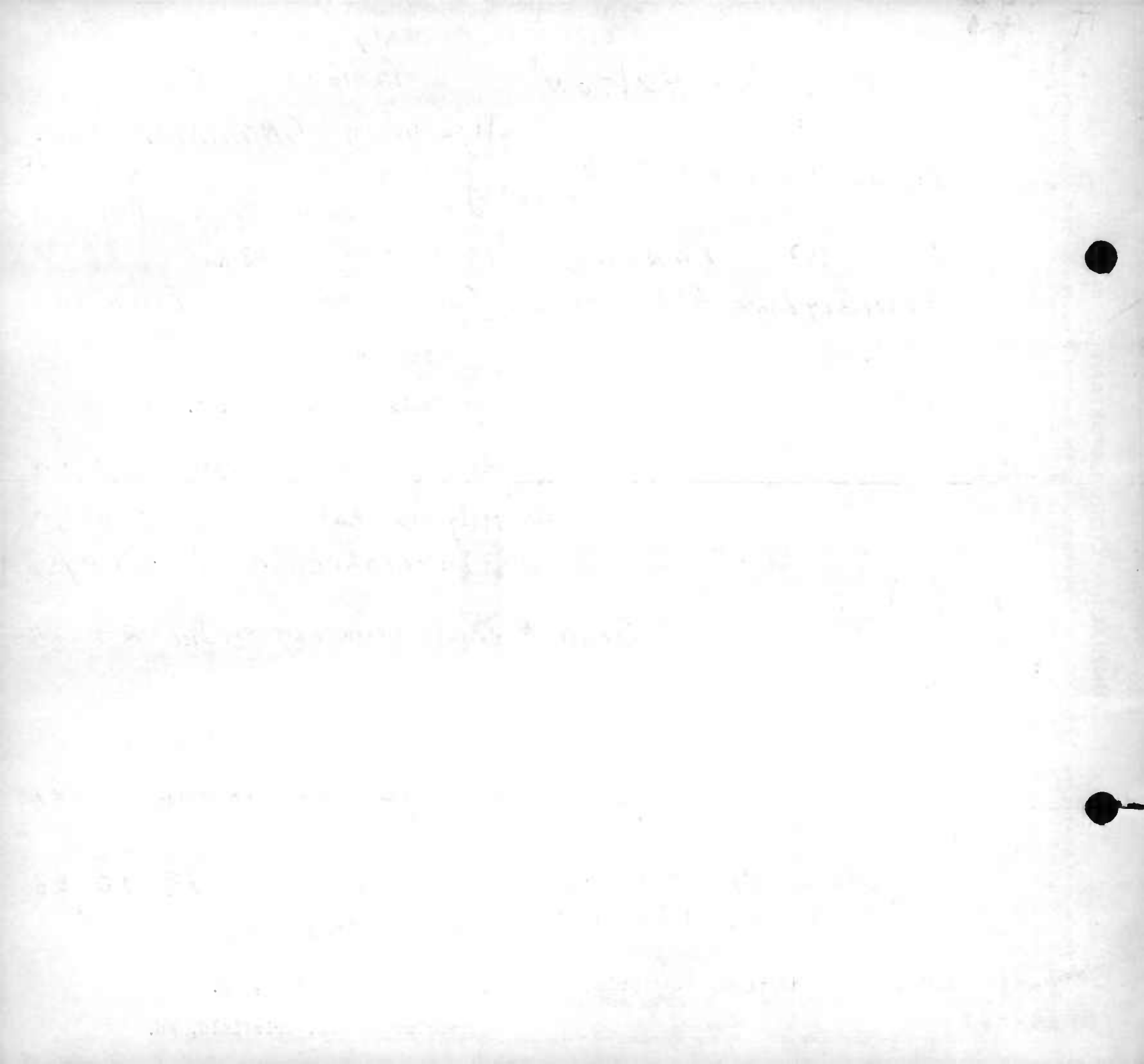
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 12637 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12637 | |
|--|-------------------------|---|------------------------------------|---|--|---|---|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Bodkins, Laura | | | | 2. DATE AND HOUR OF DEATH 12-12-66 9:35 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital (If not in hospital or institution, give street address or location) | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 19-01 | | | |
| D. STREET ADDRESS (If rural, give location) 307 Gilmore Street | | | | | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Separated | 8. DATE OF BIRTH 1/17/27 | 9. AGE (In years last birthday) 39 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Balto. Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME John Lewis | | | | 14. MOTHER'S MAIDEN NAME Edity Gortz | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Mrs. Edith Goetz - 1407 E. Baltimore St. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. If means the disease, injury or complication which caused death.) Viral Encephalitis | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 11-21 19 66 to 12-12 19 66 , that (I) (we) last saw the deceased alive on 12-12 19 66 and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE David S. Fedson M.D. | | | | | | 23B. DATE SIGNED 12-12-66 | |
| 23C. PHYSICIAN'S NAME (Type) David S. Fedson M.D. | | | | 23D. ADDRESS The Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-16-66 | | 24C. NAME OF CEMETERY or CREMATORY Glen Haven Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR John C. Miller | | 25C. FUNERAL DIRECTOR John C. Miller Inc-6415 Belair Road.-21206 | | ADDRESS | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

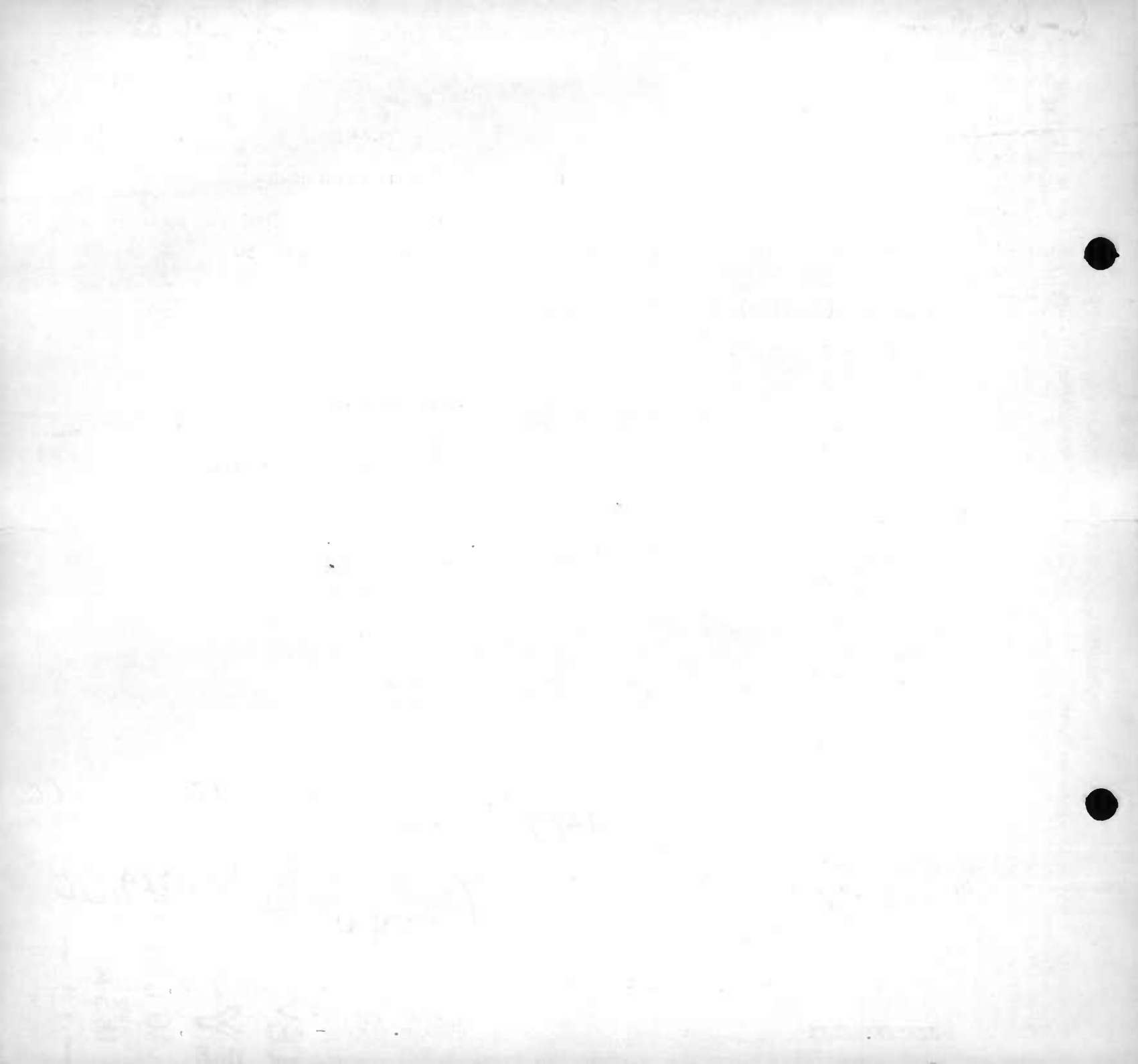
| BIRTH NO. 66 12638 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 66 12638 | |
|--|--|--|--|---|--|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) ELESTINE HUDSON | | | | 2. DATE AND HOUR OF DEATH 12.10.66 at 10 P.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL 0 4 42 BALTIMORE | | | | A. STATE MARYLAND B. COUNTY CARRIAGE City Baltimore | | | | | |
| (If not in hospital or institution, give street address or location) | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) 53-00 | | | | | |
| 5. SEX M | | | | 6. RACE W | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | | 8. DATE OF BIRTH 12.12.1917 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ASSEMBLY LINE | | 10B. KIND OF BUSINESS OR INDUSTRY ELECTRONICS | | 11. BIRTHPLACE (State or foreign country) BALTIMORE | | 9. AGE (In years last birthday) 48 yrs. | | 12. CITIZEN OF WHAT COUNTRY? AMERICA | |
| 13. FATHER'S NAME Budd L. Guy | | | | 14. MOTHER'S MAIDEN NAME Maggie Dize | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT John Lewis Hudson, Same as 4. ABCD | | | |
| 18. 296X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) CONGESTIVE CARDIAC FAILURE | | | | CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH 6 HOURS | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) HAEMOLYSIS AND | | | | 3 DAYS | |
| | | | | (C) THROMBOCYTOPENIA | | | | 3 DAYS | |
| II | | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ACUTE RUPTURED INTERVERTEBRAL Disc 2 months | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notably medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 11.16.1966 to 12.10.1966 , that (we) last saw the deceased alive on 12.10.1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Saraswaty Subbiah M.D. | | | | 23B. DATE SIGNED 12.10.66 | | | | Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/> | |
| 23C. PHYSICIAN'S NAME (Type) SARASWATY SUBBIAH M.D. | | | | 23D. ADDRESS SINAI HOSPITAL | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/14/66 | | 24C. NAME OF CEMETERY OR CREMATORY Sunnyridge Cemetery | | 24D. LOCATION (City, town, or county) (State) Crisfield, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 15 1966 | | | | 25B. NAME OF REGISTRAR Robert E. Talley | | 25C. FUNERAL DIRECTOR Bradshaw & Sons, Crisfield, Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made. **HOBERT**

| | | | |
|---|---|---|--|
| BIRTH NO. 66 12639 | | BALTIMORE CITY HEALTH DEPARTMENT | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) HOBERT CARSON | | 2. DATE AND HOUR OF DEATH 12-9-66 4:25 PM M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 THE JOHNS HOPKINS HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY ST. MARY'S Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) 68-00 D. STREET ADDRESS (If rural, give location) LEXINGTON PARK ROUTE 1 Box 13 B 1 | |
| 5. SEX MALE | 6. RACE COLORED | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) DIVORCED | 8. DATE OF BIRTH 5-16-16 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTANCE (HEATING) | | 10B. KIND OF BUSINESS OR INDUSTRY RETIRED CIVIL SERVICE | 9. AGE (In years lost birthday) 50 |
| 13. FATHER'S NAME GEORGE CARSON | | 11. BIRTHPLACE (State or foreign country) NORTH CAROLINA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 12. CITIZEN OF WHAT COUNTRY? USA | 14. MOTHER'S MAIDEN NAME HELEN WEBB |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT HOSPITAL RECORDS | |
| 18. 204.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Myeloid Leukemia | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO (B) DUE TO (C) DUE TO | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION 2 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) Yes | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? | (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/6 19 66 to 12/9 19 66 , that (I) (we) last saw the deceased alive on 12/9 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE W. Stan Wilson | | 23B. DATE SIGNED 12/9/66 | |
| 23C. PHYSICIAN'S NAME (Type) W. Stan Wilson | | 23D. ADDRESS J. H. H. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | 24B. DATE 12/13/66 | 24C. NAME OF CEMETERY or CREMATORY 1st BAPTIST CEMETERY | 24D. LOCATION (City, town, or county) (State) LEXINGTON PARK, MARYLAND |
| 25A. DATE REC'D BY HEALTH DEPT. 1966 | | 25B. NAME OF REGISTRAR John M. Welch | |
| 25C. FUNERAL DIRECTOR JOHN M. WELCH | | ADDRESS LEONARDTOWN, MARYLAND | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | | | | | |
|---|--|---------------------|--|--|--|-------------------------------------|--|--|--|---|--|------------------------------|--|--|--|--|--|--|--|
| BIRTH NO. 66 12640 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 66 12640 | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) ERNEST FRANK | | | | | 2. DATE AND HOUR OF DEATH 12/15/66 8:55 P M. | | | | | | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 46 LUTHERAN HOSPITAL OF MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 28-02 D. STREET ADDRESS (If rural, give location) 3215 Mifflin Avenue | | | | | | | | | | | | | | |
| 5. SEX M | | 6. RACE W | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married | | 8. DATE OF BIRTH 12/31/92 | | 9. AGE (in years last birthday) 73 | | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Hours: Min. | | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | | | | 10B. KIND OF BUSINESS OR INDUSTRY Self owned SON CAB | | | | | 11. BIRTHPLACE (State or foreign country) MD. | | | | | 12. CITIZEN OF WHAT COUNTRY? U.S. A. | | | | |
| 13. FATHER'S NAME John Frank | | | | | 14. MOTHER'S MAIDEN NAME Anna Krantz | | | | | | | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | | 16. SOCIAL SECURITY NO. 218-07-4068 | | | | | 17. INFORMANT Mrs. Beatrice M. Frank | | | | | ADDRESS same as 40 | | | | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) MYOCARDIAL INFARCTION GENERALIZED ARTERIOSCLEROSIS | | | | | | | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| II DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION 2 | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20A. AUTOPSY? (Yes or No) YES | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/15 19 66 to 12/15 19 66 , that (I) (we) last saw the deceased alive on 12/15/66 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 23A. SIGNATURE Desiderio L. Hedrow, Jr. M.D. | | | | | | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | | 23B. DATE SIGNED 12/17/66 | | | | |
| 23C. PHYSICIAN'S NAME (Type) DESIDERIO L. HEDROW, JR. M.D. | | | | | | | | | | 23D. ADDRESS Lutheran Hospital of Maryland | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | | 24B. DATE 12/19/66 | | | | | 24C. NAME OF CEMETERY or CREMATORY Druid Ridge | | | | | 24D. LOCATION (City, town, or county) (State) Pikesville Md. | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | | 25B. NAME OF REGISTRAR John T. Stansbury Sr. | | | | | 25C. FUNERAL DIRECTOR John T. Stansbury Sr. | | | | | ADDRESS 6411 Windsor Mill | | | | |

DEC 19 1966

IN SENATE,
January 1, 1901.

REPORT OF THE
COMPTROLLER

FOR THE YEAR
1900.

ALBANY:
J. B. LIPPINCOTT & CO.,
PRINTERS.

ALBANY:
J. B. LIPPINCOTT & CO.,
PRINTERS.

ALBANY:
J. B. LIPPINCOTT & CO.,
PRINTERS.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. 66 12641 | | CERTIFICATE OF DEATH | | Registered No. 66 12641 | |
|--|-------------------------|---|--|---|--|--|---|---|--|
| 1. NAME OF DECEASED (Type or Print) BECHLER, MARGARET ELIZABETH | | | | 2. DATE AND HOUR OF DEATH DECEMBER 13, 1966 3:30P. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 ST. AGNES HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY Balt. Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21227 33-00 D. STREET ADDRESS (If rural, give location) 1514 CLAIRIDGE RD. | | | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW | 8. DATE OF BIRTH 6-27-89 | 9. AGE (In years last birthday) 77 | If Under 1 Yr. Months: Days: Hours: Min. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | | | 10B. KIND OF BUSINESS OR INDUSTRY NONE | | | 11. BIRTHPLACE (State or foreign country) IRELAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JAMES Fearon | | | | 14. MOTHER'S MAIDEN NAME ELIZABETH FEARON McShane | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE | | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT ADDRESS ST. AGNES HOSPITAL RECORDS 21229 | | | | |
| 18. 13 4X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Intestinal obstruction & peritonitis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH (A) Intestinal obstruction & peritonitis (B) Lacuna recto-sigmoid area (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH began 11-20-1966 to 12-13-1966 | | | |
| 19A. DATE OF OPERATION 12-3-1966 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Intestinal obstruction | | 20A. AUTOPSY? (Yes or No) yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from DECEMBER 3 19 66 to DECEMBER 13 19 66 , that (I) (we) lost saw the deceased alive on DECEMBER 13 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Carl H Matthey | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED 12-13-1966 | |
| 23C. PHYSICIAN'S NAME (Type) CARL H MATTHEY | | | | 23D. ADDRESS M.D. ST. AGNES HOSP; CATON & WILKENS AVES. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Dec. 16, 1966 | | 24C. NAME of CEMETERY or CREMATORY Loudon Park Cem. | | 24D. LOCATION (City, town, or county) (State) Balto, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 10 1966 | | 25B. NAME OF REGISTRAR R. D. E. Johnson | | 25C. FUNERAL DIRECTOR G. Truman Schwab | | | | ADDRESS 3512 Frederick Ave. Balto. Md | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | | | | | |
|---|-------------------|---|--|--|---|--|--|--------------------------------------|--|--|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | BIRTH NO. 66 12642 | | CERTIFICATE OF DEATH | | Registered No. 66 12642 | | | | | |
| 1. NAME OF DECEASED (Type or Print) GLADYS MICHEL | | | | 2. DATE AND HOUR OF DEATH 12-15-1966 1.35A M. | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSP. of MARYLAND (If not in hospital or institution, give street address or location) | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE BALTIMORE B. COUNTY MARYLAND C. CITY OR TOWN (If outside city limits, write RURAL and give township) 3433 Old Frederick Rd BALTIMORE D. STREET ADDRESS (If rural, give location) 3433 Old Frederick Rd | | | | | | | |
| 5. SEX F. | 6. RACE W. | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | | 8. DATE OF BIRTH Dec. 14, 1912 | 9. AGE (In years last birthday) 54 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H House Wife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Hamburg New York | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | | |
| 13. FATHER'S NAME UNKNOWN | | | | 14. MOTHER'S MAIDEN NAME UNKNOWN | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Balto. Md. Mr. John I. Michel Sr. 3433 Old Frederick Rd. | | ADDRESS | | | | | |
| 18. 13-0X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) CANCER of STOMACH DUE TO (B) CANCER of ESOPHAGUS DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 6 months | | | | | |
| | | | | | | | | 19. DATE OF OPERATION 7-14-66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Good | |
| | | | | | | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-14-1966 to 12-15-1966 , that (I) (we) last saw the deceased alive on 12-14-1966 and that in my (our) opinion death occurred on the date and hour and from the cause stated above. (I) (We) (did) (and not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE Joseph R. Sturich M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-15-66 | | | | | |
| 23C. PHYSICIAN'S NAME (Type) JOSE R. STURICH M.D. | | | | 23D. ADDRESS 2519 gatehouse Dr. BALTO. Md. | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Dec. 17, 1966 | | 24C. NAME of CEMETERY or CREMATORY New Cathedral Cem. | | 24D. LOCATION (City, town, or county) (State) Balto. Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 10 1966 | | 25B. NAME OF REGISTRAR Robert E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS G. Truman Schwab 3512 Frederick Ave. Balto. | | | | | | | |

1952-1953

NICHOL

~~James - Mary~~

~~3433 (24/10/52)~~

3433 (24/10/52)

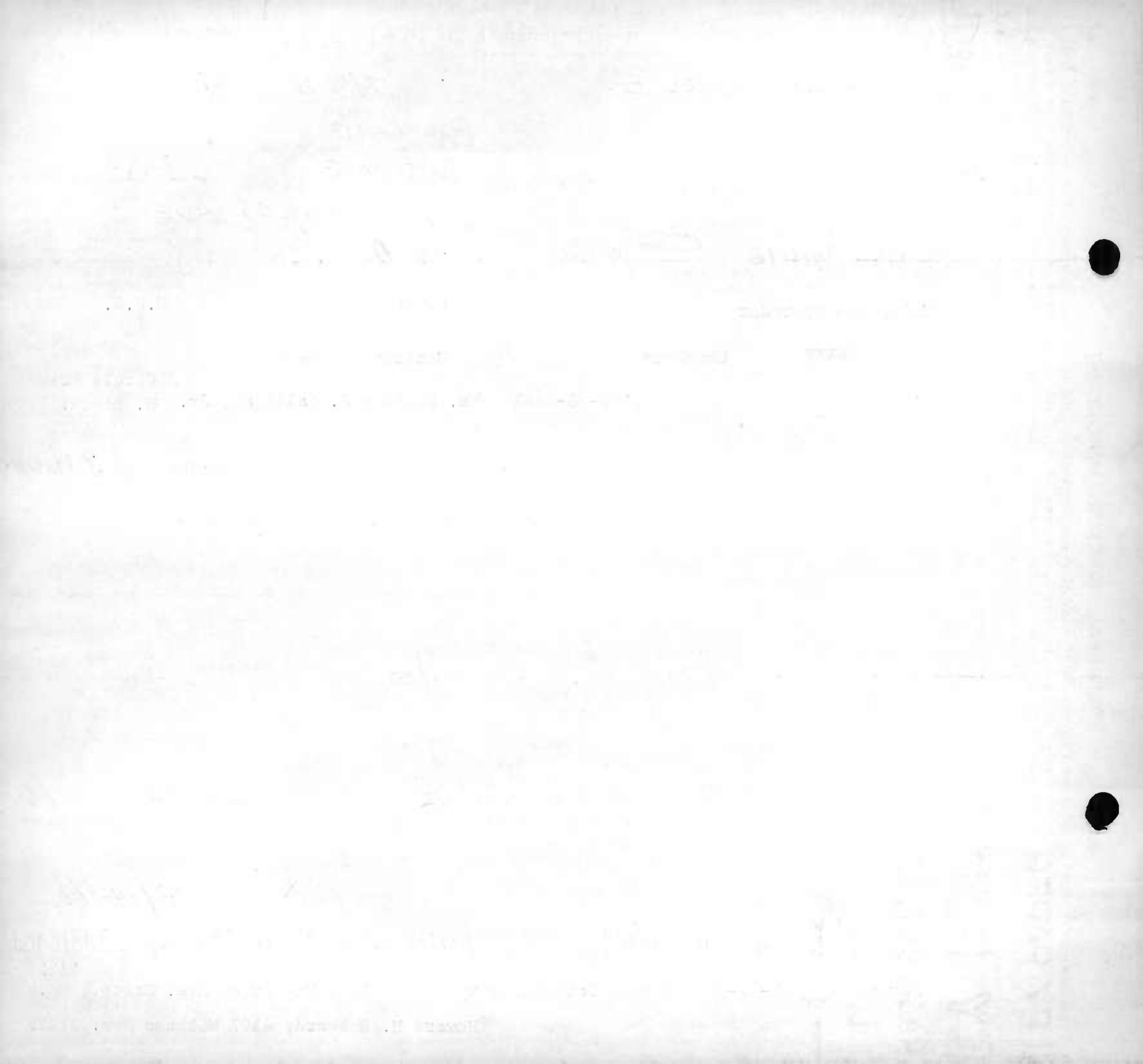
1952-1953

3433 (24/10/52)

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 12643</u> | |
|--|--|---|--|--|--|
| BIRTH NO. <u>66 12643</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>HALLIGAN, MABEL E.</u> | | 2. DATE AND HOUR OF DEATH <u>12/14/66 3:45 PM</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> | | M. | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>LUTHERAN HOSPITAL OF MARYLAND</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> | | 25-43 | |
| D. STREET ADDRESS (If rural, give location) <u>1917 GRAYNOLDS AVE</u> | | E. DATE OF BIRTH <u>10-4-06</u> | | F. AGE (In years last birthday) <u>60</u> | |
| G. SEX <u>FEMALE</u> | | H. RACE <u>WHITE</u> | | I. MARRIED, NEVER MARRIED <u>WIDOWED</u> DIVORCED (specify) <u>Widowed</u> | |
| J. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telephone Operator</u> | | K. KIND OF BUSINESS OR INDUSTRY | | L. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| M. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | N. FATHER'S NAME <u>Harry Chambers</u> | | O. MOTHER'S MAIDEN NAME <u>Gertrude Hankins</u> | |
| P. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | Q. SOCIAL SECURITY NO. <u>215-03-3463</u> | | R. INFORMANT <u>Mr. Phillip J. Halligan, Jr.</u> | |
| S. ADDRESS <u>2 Circle Drive</u> | | T. ADDRESS <u>N. Linth. 21090</u> | | | |
| 18. <u>200.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) <u>LYMPHOSARCOMA & HEPATOMEGALY</u> DUE TO (B) <u>LEUKEMIC PHASE, TERMINAL</u> DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH <u>48 HOURS</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTO. SY? (Yes or No) <u>Yes.</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Dec 13, 1966</u> to <u>Dec 14, 1966</u> , that (I) (we) last saw the deceased alive on <u>Dec 14, 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Young Kil Kim</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>12/14/66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>YOUNG KIL KIM</u> | | M.D. 23D. ADDRESS <u>LUTHERAN HOSPITAL OF MARYLAND</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12-17-66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park Cemetery</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>3801 Frederick Ave. Balto., Md.</u> | | 24E. DATE REC'D BY HEALTH DEPT. <u>DEC 18 1966</u> | | 24F. NAME OF REGISTRAR <u>Dr. E. J. Taylor</u> | |
| 24G. FUNERAL DIRECTOR <u>Howard H. Hubbard</u> | | 24H. ADDRESS <u>4107 Wilkens Ave. 21229</u> | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12644 | |
|--|------------------|--|---------------------------------|---|---|
| BIRTH NO. 66 12644 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) ROBERT A. WINN | | 2. DATE AND HOUR OF DEATH 12/15/66 6.15 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL | | A. STATE Md. B. COUNTY | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 2542 | | | |
| | | D. STREET ADDRESS (If rural, give location) 2607 NORTSHIRE DR. #30 | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) M | 8. DATE OF BIRTH 6/29/18 | 9. AGE (In years last birthday) 48 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEEL WORKER | | 10B. KIND OF BUSINESS OR INDUSTRY BETHLEHEM STEEL CO. | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A | | 13. FATHER'S NAME Richard J. Winn | | 14. MOTHER'S MAIDEN NAME Katherine Stumpf | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) WWII | | 16. SOCIAL SECURITY NO. 216-03-2329 | | 17. INFORMANT ADDRESS Wife: ESTHER, SAME | |
| 18. 201X I | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) HODGKIN'S DISEASE | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | (B) DUE TO | | | |
| ANTECEDENT CAUSES | | (C) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/24/1966 to 12/15/1966 , that (I) (we) last saw the deceased alive on 11/15/1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Eduardo Hidalgo M.D. | | | | 23B. DATE SIGNED 12/15/66 | |
| 23C. PHYSICIAN'S NAME (Type) EDUARDO HIDALGO M.D. | | | | 23D. ADDRESS SINAI HOSPITAL, BALT. Md | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-19-66 | | 24C. NAME OF CEMETERY or CREMATORY Meadowridge Cemetery | |
| 24D. LOCATION (City, town, or county) Howard County, Maryland | | 24E. DATE REC'D BY HEALTH DEPT. DEC 18 1966 | | 24F. NAME OF REGISTRAR R. J. Hubbard | |
| 24G. DATE REC'D BY HEALTH DEPT. DEC 18 1966 | | 24H. NAME OF REGISTRAR R. J. Hubbard | | 24I. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229 | |

GRAND HOSPITAL

WILLIAM H. BARNETT
WILLIAM H. BARNETT
WILLIAM H. BARNETT

M W M

11/11/18

WILLIAM H. BARNETT
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W

11/12

WILLIAM H. BARNETT
WILLIAM H. BARNETT
WILLIAM H. BARNETT

WILLIAM H. BARNETT
WILLIAM H. BARNETT
WILLIAM H. BARNETT

11/12/18

WILLIAM H. BARNETT
WILLIAM H. BARNETT
WILLIAM H. BARNETT

BIRTH NO.

M.E. CASE NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED
(Type or Print)

MARY E. COSGROVE

2. DATE AND HOUR PRONOUNCED DEAD

December 13, 1966

12:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

40 St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Massachusetts

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Milton

D. STREET ADDRESS (If rural, give location)

21 Antwerp Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

June 2, 1894

9. AGE (In years
last birthday)

72

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Ireland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Joseph Stinton

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Johnston Funeral Home, Milton Massachusetts

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Multiple Traumatic Injuries.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Rt. 1, Savage, Maryland

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
12 13 '66 A.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Passenger in auto into fixed object.

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/13/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12-17-66

23C. NAME of CEMETERY or CREMATORY

St. Francis Cemetery

23D. LOCATION

(City, town, or county)

(State)

Weymouth, Massachusetts

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

DEC 10 1966

R. E. E. F. J. J. J.

Howard H. Hubbard, 4107 Wilkens Ave. 21229

WALTON & POTTING

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO. _____

M.E. CASE NO. _____

1. NAME OF DECEASED
(Type or Print)

EARL P BARNETT

2. DATE AND HOUR PRONOUNCED DEAD

December 15, 1966 5:00 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

261 Robert Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

261 Robert Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

5/19/22

9. AGE (In years last birthday)

44

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Unemployed

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Pernell Barnett

14. MOTHER'S MAIDEN NAME

Hazel I

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW 2

16. SOCIAL SECURITY NO.

17. INFORMANT

Mr Pernell Barnett 2305 Ellamont St

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO **Cirrhosis of liver**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Charles S. Springate, M.D.
EXAMINER'S NAME (Type)

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

December 16, 1966

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

12/21/66

23C. NAME of CEMETERY or CREMATORY

National Cemetery

23D. LOCATION

Baltimore Md

24A. DATE REC'D BY HEALTH DEPT.

DEC 19 1966

24B. NAME OF REGISTRAR

Adolphus Halstead

24C. FUNERAL DIRECTOR

Adolphus Halstead 1206 W North Ave

ADDRESS

RECEIVED

FOUR

RECEIVED

RECEIVED

RECEIVED

RECEIVED

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 66 12647 | |
|---|---------------|--|-----------------------------------|--|--|--|-------------------------------------|
| BIRTH NO. 66 12647 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Lee, Mrs. Maggie | | 2. DATE AND HOUR OF DEATH 12-18-66 3:45 a.m. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hospital 34 | | | | A. STATE Md. B. COUNTY | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21223 20-01 | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 1950 W. Fayette St. | | | |
| 5. SEX F | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOW | 8. DATE OF BIRTH ? 1903 | 9. AGE (In years last birthday) 63 | If Under 1 Yr. Months: Days: Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) South Carolina | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Lee, Golden | | | | 14. MOTHER'S MAIDEN NAME Smith, Ida | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Admission Sheet | | ADDRESS |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH (A) Pneumonia, right upper lobe DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 1 week - 10 days | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO | | | |
| | | | | (C) DUE TO | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | Anterior sclerotic Ht. Disease w. Congest. Ht. Failure MONTHS | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (M) (this hospital) attended the deceased from Dec 17 19 66 to Dec 18 19 66, that (M) (we) last saw the deceased alive on Dec 18 19 66 and that in (M) (our) opinion death occurred on the date and hour and from the causes stated above. (M) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Dong Sup Cha | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED Dec 18 1966 | |
| 23C. PHYSICIAN'S NAME (Type) Dong Sup Cha | | | | 23D. ADDRESS M.D. Bon Secours Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/22/66 | | 24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore Md | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 18 1966 | | 25B. NAME OF REGISTRAR Robert E. Feltner | | 25C. FUNERAL DIRECTOR Adolphus Halstead | | ADDRESS 1206 W North Ave | |

Domestic

South America

Patronage, right of

Antisocialistic measures in regard to labor

William H.

John W. Adams

1877

John W. Adams, 1877

66 12648

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66 12648

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM McROY

2. DATE AND HOUR PRONOUNCED DEAD

12-11-66

3:15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

PROVIDENT HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2429 Reisterstown Road 21217

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

JUL 18, 1921

9. AGE (in years
last birthday)

45

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTIMORE MD

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

WILLIAM McROY SR.

14. MOTHER'S MAIDEN NAME

ADDIE SCOTT

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

DOROTHY WELLS

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Massive internal bleeding
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Stab wound of abdomen, involving
left iliac artery
(C)OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

2429 Reisterstown Road

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
12 11 '66 2:44 PM

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Stabbed in abdomen

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE

EXAMINER'S

NAME (Type) WERNER U. SPITZ, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-12-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

12-19-66

23C. NAME of CEMETERY or CREMATORY

BAC TO NAT'L CEM

23D. LOCATION

(City, town, or county)

(State)

BALTO, Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

I. L. BROWN + Son

123 W. MONTGOMERY ST.

1
S-300

| BALTIMORE CITY HEALTH DEPARTMENT | | | |
|--|---|---|---------------------------------|
| 66 12649 BIRTH NO. 66-21430 | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12649 | |
| M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR PRONOUNCED DEAD | |
| ZELDA SCOTT | | December 9, 1966 7:40 A. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE Maryland B. COUNTY Baltimore | |
| 43 South Baltimore Hospital | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 126 W. Lee Street | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH |
| 9. AGE (In years last birthday) | 10. BIRTHPLACE (State or foreign country) | | 11. CITIZEN OF WHAT COUNTRY? |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 12. CITIZEN OF WHAT COUNTRY? | |
| Child | | | |
| 13. FATHER'S NAME Raymond Scott | | 14. MOTHER'S MAIDEN NAME Bernadette Scott | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| | | 17. INFORMANT Bernadette Scott 131-W. Lee Street | |
| 18. CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) Interstitial pneumonitis (SDII) DUE TO | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) DUE TO | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (C) DUE TO | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? | | 21D. TIME OF INJURY (APPROX.) | |
| 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| 21G. HOW DID INJURY OCCUR? | | 21H. HOW DID INJURY OCCUR? | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| Charles S. Springate, M.D. | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| December 9, 1966 | | DATE SIGNED | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | |
| Burial | | 12-12-66 | |
| 23C. NAME OF CEMETERY or CREMATORY | | 23D. LOCATION (City, town, or county) (State) | |
| Mt Auburn Cemetery | | Baltimore, City | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | |
| DEC 10 1966 | | Isaiah L. Brown and Son | |
| 24C. FUNERAL DIRECTOR | | ADDRESS | |
| 108 W. Montgomery Street | | | |

100-100000

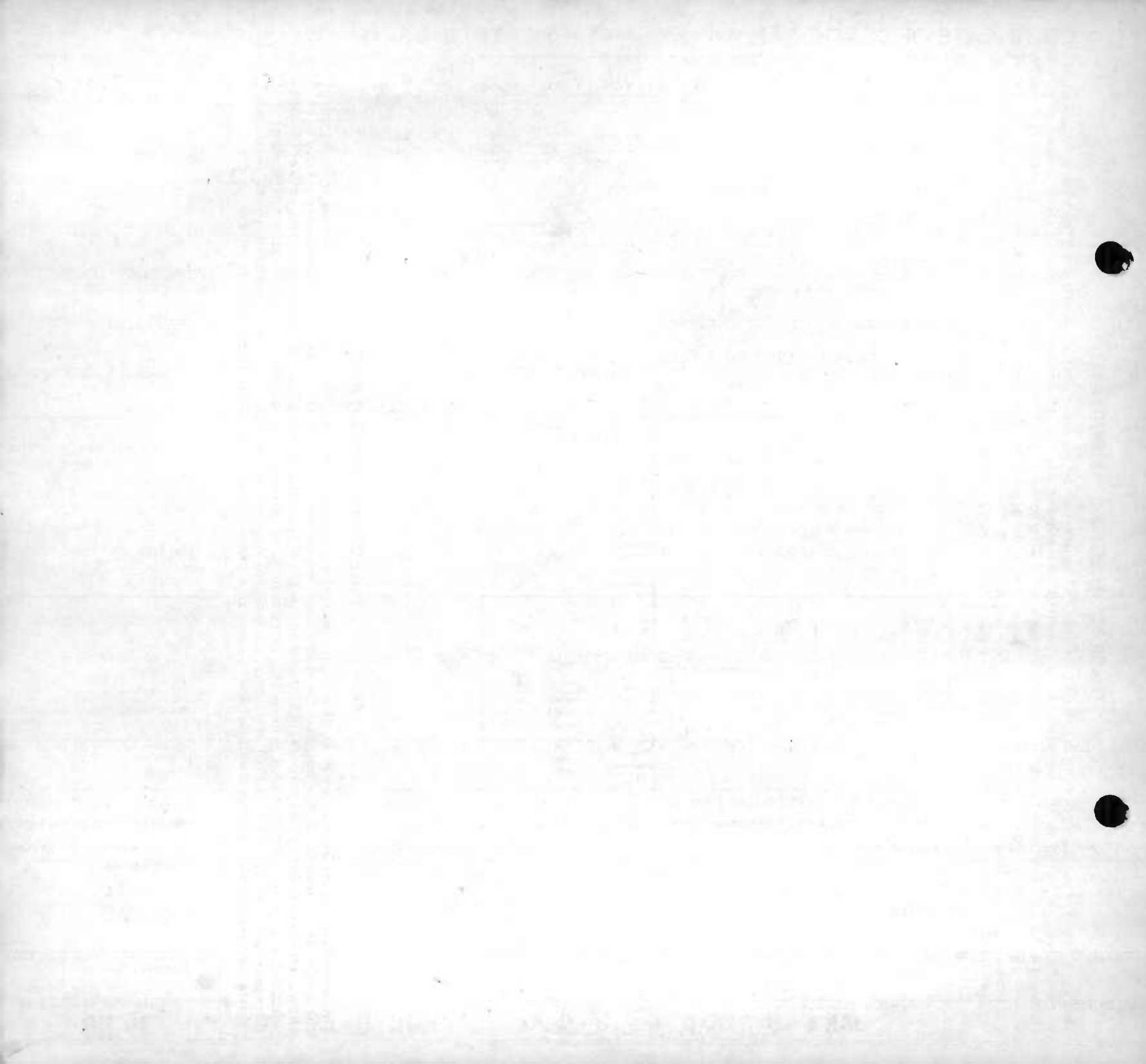
WATKINS

12-12-33 at Auburn Cemetery
Isabel A. Brown and son
100-100000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|--|--|--|--|
| BIRTH NO. 66 12650 66-27943 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12650 | |
| CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED (Type or Print) BABY GIRL ADKINSON B | | | 2. DATE AND HOUR OF DEATH 12-28-66 3.30 P. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 35 Church Home and Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Baltimore B. COUNTY 8-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Maryland 13, D. STREET ADDRESS (If rural, give location) 3138 Clifftmont Ave | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) 5 | 8. DATE OF BIRTH Dec 28, 1966 | 9. AGE (In years lost birthday) | If Under 1 Yr. Months Days Hours If Under 24 Hrs. 24 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | | |
| 13. FATHER'S NAME Mr. David William Adkinson | | | 14. MOTHER'S MAIDEN NAME Mildred Simpson | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS 3138 Clifftmont Ave | |
| 18. 7-59-31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) MULTIPLE CONGENITAL ABNORMALITIES (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE J. William Dorman Jr. | | | 23B. DATE SIGNED 12-28-66 | | |
| 23C. PHYSICIAN'S NAME (Type) | | | 23D. ADDRESS | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE JAN 4 1967 | | 24C. NAME OF CEMETERY or CREMATORY UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 5 1967 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | Registered No. <u>86 12651</u> | |
|---|--|---|--|--|--|
| <div> <div>BIRTH NO. <u>66 12651</u></div> <div>M.E. CASE NO. <u>66 12651</u></div> <div>1. NAME OF DECEASED (Type or Print) <u>STARTT, BABY GIRL</u></div> <div>2. DATE AND HOUR OF DEATH <u>DEC. 14, 1966</u> <u>8:04 A.M.</u></div> </div> | | | | | |
| <div>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</div> <div> <div>FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIVERSITY HOSPITAL</u> <u>38</u></div> <div>(If not in hospital or institution, give street address or location)</div> </div> | | | <div>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</div> <div> <div>A. STATE <u>MARYLAND</u></div> <div>B. COUNTY <u>Queen Anne</u></div> </div> | | |
| <div>5. SEX <u>FEMALE</u></div> <div>6. RACE <u>WHITE</u></div> <div>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>NEVER MARRIED</u></div> | | | <div>8. DATE OF BIRTH <u>12/1/66</u></div> <div>9. AGE (In years last birthday) <u>13 days</u></div> <div>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> | | |
| <div>11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u></div> <div>12. CITIZEN OF WHAT COUNTRY? <u>USA</u></div> | | | <div>13. FATHER'S NAME <u>GARRETT B. STARTT</u></div> <div>14. MOTHER'S MAIDEN NAME <u>PHYLLIS A. WILLIAMS</u></div> | | |
| <div>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u></div> <div>16. SOCIAL SECURITY NO. <u>—</u></div> <div>17. INFORMANT <u>PARENTS</u></div> | | | <div>18. <u>706.21</u></div> <div>CAUSE OF DEATH</div> <div> <div>(A) <u>ASPIRATION</u></div> <div>DUE TO</div> <div>(B) <u>GASTRIC DILATATION</u></div> <div>DUE TO</div> <div>(C) <u>JEJUNAL ATRESIA (POST-OPERATIVELY)</u></div> </div> | | |
| <div>19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</div> <div>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</div> <div>ANTECEDENT CAUSES</div> <div>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</div> | | | <div>INTERVAL BETWEEN ONSET AND DEATH <u>5 HOURS</u></div> | | |
| <div>II</div> <div>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>NONE</u></div> | | | | | |
| <div>19A. DATE OF OPERATION <u>12/3/66</u></div> <div>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>JEJUNAL ATRESIA</u></div> | | <div>20A. AUTOPSY? (Yes or No) <u>—</u></div> <div>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</div> | | <div>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>—</u></div> <div>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u></div> | |
| <div>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u></div> | | <div>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>—</u></div> <div>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Net While At Work <input type="checkbox"/></div> | | <div>21F. HOW DID INJURY OCCUR? <u>—</u></div> | |
| <div>22. I certify that (I) (this hospital) attended the deceased from <u>DECEMBER 2, 1966</u> to <u>DECEMBER 14, 1966</u>, that (I) (we) lost saw the deceased alive on <u>DECEMBER 14, 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</div> | | | | | |
| <div>23A. SIGNATURE <u>Charles M. Harrison</u> M.D.</div> <div>23B. DATE SIGNED <u>12/14/66</u></div> | | | | <div>23C. PHYSICIAN'S NAME (Type) <u>CHARLES M. HARRISON</u> M.D.</div> <div>23D. ADDRESS <u>UNIVERSITY HOSPITAL</u></div> | |
| <div>24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u></div> <div>24B. DATE <u>12-14-66</u></div> | | <div>24C. NAME of CEMETERY or CREMATORY <u>Still Cemetery</u></div> <div>24D. LOCATION (City, town, or county) (State) <u>Still Pond Kent Md.</u></div> | | <div>25A. DATE REC'D BY HEALTH DEPT. <u>DEC 10 1966</u></div> <div>25B. NAME OF REGISTRAR <u>Robert E. Jackson</u></div> | |
| <div>25C. FUNERAL DIRECTOR <u>Victor M. Kennedy</u></div> <div>25D. ADDRESS <u>Still Pond, Md.</u></div> | | | | <div>25E. DATE REC'D BY HEALTH DEPT. <u>DEC 10 1966</u></div> <div>25F. NAME OF REGISTRAR <u>Robert E. Jackson</u></div> | |

CHARLES M. HARRISON
Charles M. Harrison

Residence: Little County
Little M. County

12/14/40
UNIVERSITY HOSPITAL

December 14, 40
December 7, 40

RETUMAL ATRESIA

KNOX

(POST-OPERATIVE)
RETUMAL ATRESIA

RETUMAL ATRESIA

ASPIRATION

PARENTS

GARETT B. STARRT

WILLIAM A. WILLIAMS

MARYLAND

FEMALE WHITE NEVER MARRIED 12/1/40 12 days

UNIVERSITY HOSPITAL

CENTREVILLE
MARYLAND

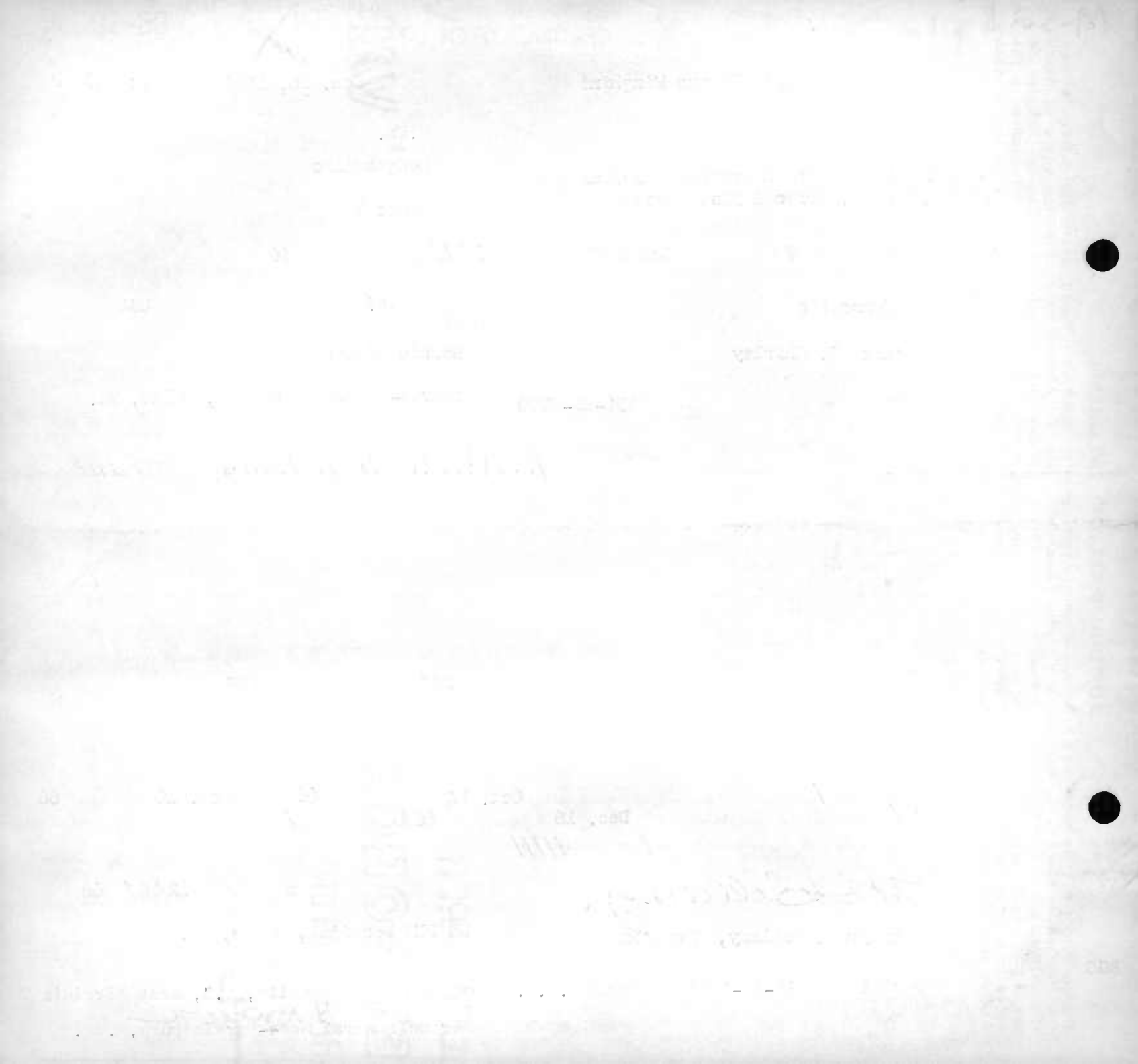
START, BABY GIRL

Dec 14, 1940

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|---|--------------------------------|---|--|--|--|
| BIRTH NO. 66 12652 | | CERTIFICATE OF DEATH | | 66 12652 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Lillie Havana Minghini | | | 2. DATE AND HOUR OF DEATH Dec. 16, 1966 1: 05 P M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Public Health Service Hospital Wyman Pk. Drive & 31st Street | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE W. Va. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Hedgesville D. STREET ADDRESS (If rural, give location) Route 2 | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 3/14/00 | 9. AGE (In years last birthday) 66 | If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Va. | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Daniel F. Shirley | | | 14. MOTHER'S MAIDEN NAME Nannie Sirbaugh | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 236-01-8790 | 17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md. | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple Myeloma INTERVAL BETWEEN ONSET AND DEATH months DUE TO (A) _____ (B) _____ (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) yes | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from Oct. 24 19 66 to Dec. 16 19 66 , that (I) (we) last saw the deceased alive on Dec. 16 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE M. Bellamy M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED 12/16/ 66 | | |
| 23C. PHYSICIAN'S NAME (Type) Murlyn D. Bellamy, Surgeon | | 23D. ADDRESS M.D. US PHS Hospital, Balto, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 12-19-1966 | 24C. NAME OF CEMETERY or CREMATORY Central E.U.B. Cemetery | 24D. LOCATION (City, town, or county) (State) Hedgesville, Rt. 2, West Virginia | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 10 1966 | | 25B. NAME OF REGISTRAR Robert E. Fairburn | 25C. FUNERAL DIRECTOR ADDRESS Brown Funeral Home-Martinsburg, W. Va. | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>168</u> | |
|---|---------------------|--|---|--|--|
| 66 12653 | | | | 66 12653 | |
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>EDWARD MONAGHAN</u> | |
| 2. DATE AND HOUR OF DEATH <u>12-17-66</u> <u>7:00 A.M.</u> | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <u>MERCY HOSPITAL BALTO.</u> B. COUNTY <u>MARYLAND</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> | | | |
| D. STREET ADDRESS (If rural, give location) <u>606 E. BALTO. ST.</u> | | FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>BOLTON HILK NURSING & CONV. CENTER</u> <u>1400 JOHN ST.</u> <u>BALTO. MD 21217</u> | | | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>SEPARATED</u> | 8. DATE OF BIRTH <u>MAY 14, 1916</u> | 9. AGE (In years lost birthday) <u>70</u> | If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>IN RESTAURANT</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>JOHN MONAGHAN</u> | | 14. MOTHER'S MAIDEN NAME <u>ROSE MARY MURRAY</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>216092026</u> | | 17. INFORMANT ADDRESS <u>Frank J. Monaghan - 4232 M. Lford Rd</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>1/62.1 I</u> | | CAUSE OF DEATH (A) <u>Benign prostatic neoplasm</u> (B) <u>atrial fibrillation</u> (C) <u>anemia</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>1/66</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>12-17-66</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>NO</u> | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <u>NO</u> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1/10</u> 19 <u>66</u> to <u>12/17</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12/17</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>allan h. macht</u> M.D. | | | | 23B. DATE SIGNED <u>12/17/66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>A ALLAN H. MACHT M.D.</u> | | | | 23D. ADDRESS <u>2 EAST READ ST</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>12-20-66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral Cemetery</u> | |
| 24D. LOCATION (City, town, or county) <u>BALTIMORE, MARYLAND</u> | | 24E. NAME OF REGISTRAR <u>Ellsworth Armacost</u> | | 24F. FUNERAL DIRECTOR ADDRESS <u>4600 Liberty</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 18 1966</u> | | 25B. NAME OF REGISTRAR <u>Ellsworth Armacost</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>4600 Liberty</u> | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---|------------------|---|-----------------------------|--|---|
| BIRTH NO. 30066 12654 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12654 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) OTTO, ^{EX} IRA-L. | | 2. DATE AND HOUR OF DEATH 12/16/66 2:10 PM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE MARYLAND B. COUNTY Balto Co. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 33-00 | |
| FULL NAME OF HOSPITAL OR INSTITUTION 46 LUTHERAN HOSPITAL OF MARYLAND | | D. STREET ADDRESS (If rural, give location) 116 SMITHWOOD AVE | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH 6/30/18 | 9. AGE (In years lost birthday) 48 | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant | | 10B. KIND OF BUSINESS OR INDUSTRY Alex & Alex | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME Late - Ira C. Otto | | 14. MOTHER'S MAIDEN NAME Bessie Gilbert | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 213-18-8605 | | 17. INFORMANT Mrs. Ira Otto 116 Smithwood Ave. | |
| 18. 199.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Abdominal Carcinomatosis DUE TO (B) Sarcoma - Left Lower Extremity. DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from December 16, 1966 to December 14, 1966, that (I) (we) lost saw the deceased alive on December 16, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did nat) view the body after death. | | | | | |
| 23A. SIGNATURE Young Kil Kim | | | | 23B. DATE SIGNED 12/16/66 | |
| 23C. PHYSICIAN'S NAME (Type) YOUNG KIL KIM | | | | 23D. ADDRESS LUTHERAN HOSPITAL OF MD. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-19-66 | | 24C. NAME OF CEMETERY or CREMATORY Pipe Creek Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Carroll County, Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR Witzke F.D. 4101 Edmondson Ave. | |

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66 12655

BALTIMORE CITY HEALTH DEPARTMENT

66 12655

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)M.
ALBERT WOLFF

2. DATE AND HOUR PRONOUNCED DEAD

December 16, 1966 8:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

40 St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

Balt. Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

53-00

D. STREET ADDRESS (If rural, give location)

1203 Maiden Choice Lane

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Sept. 29, 1892

9. AGE (In years
last birthday)

74

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Fireman

10B. KIND OF BUSINESS OR INDUSTRY

Baltimore City

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Frederick Wolff

14. MOTHER'S MAIDEN NAME

Frances

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

217-48-2227

17. INFORMANT

Mrs. Albert M. Wolff

ADDRESS

1203 Maiden Choice Lane - 29

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Ruptured arteriosclerotic
abdominal aortic aneurysm

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURECharles S. Springate, M.D.
EXAMINER'S NAME (Type)CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

December 16, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12-19-66

23C. NAME of CEMETERY or CREMATORY

Lorraine Park Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

DEC 19 1966

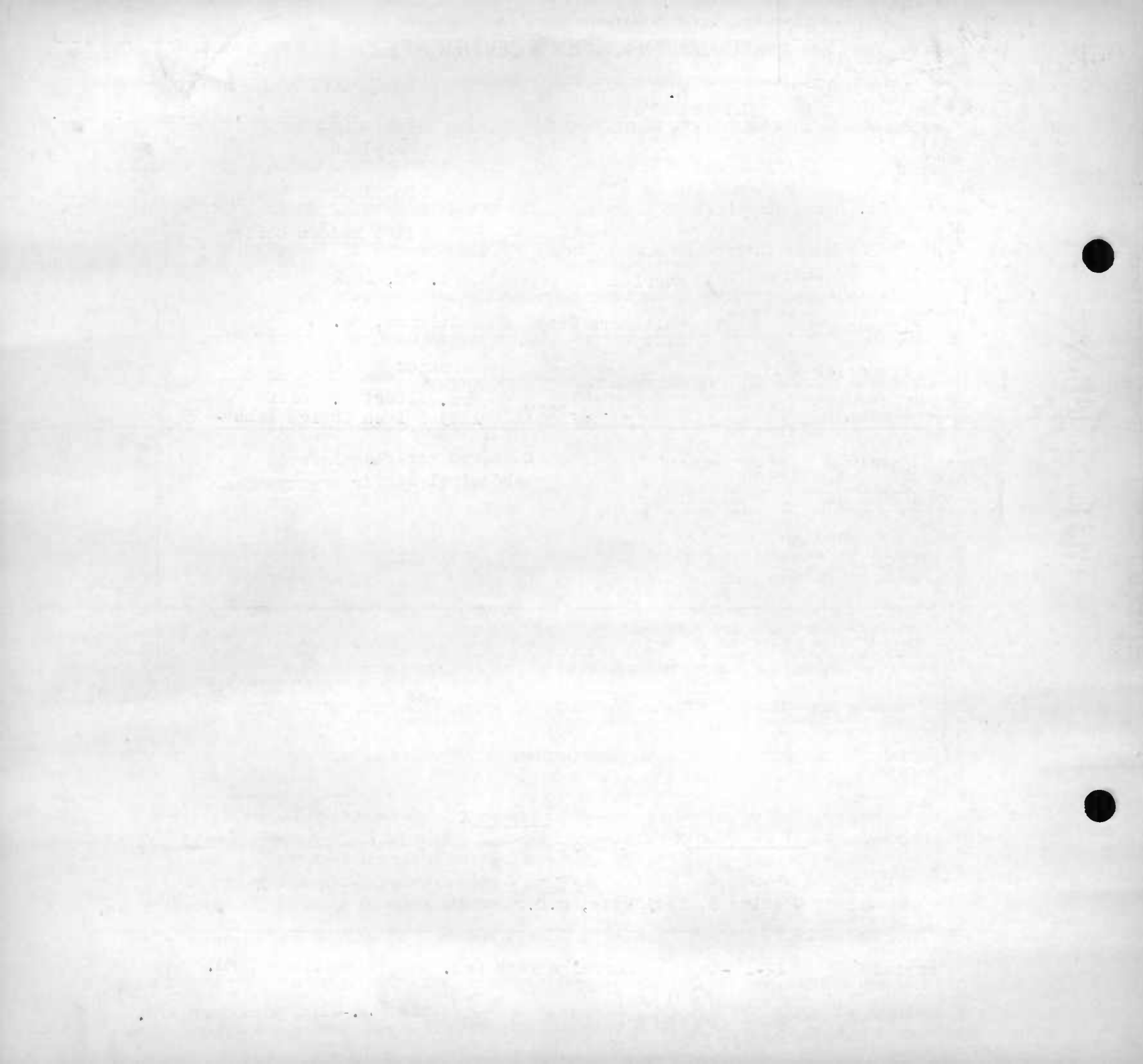
24B. NAME OF REGISTRAR

Robert E. Springate, M.D.

24C. FUNERAL DIRECTOR

Witzke F.D.-4101 Edmondson Ave.

ADDRESS



CERTIFICATE OF DEATH

Registered No. 66 12656

BIRTH NO.

66 12656

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Sadie Young

2. DATE AND HOUR OF DEATH

12-14-66

11:00P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland # 21224

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1921 Etting Street #21217

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

3-14-1890

9. AGE (In years
last birthday)

76

If Under 1 Yr. If Under 24 Hrs.
Months: Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR INDUSTRY

Pvt. Family

11. BIRTHPLACE (State or foreign country)

Maryland (Church Hill)

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles W. Wesley Boardley

14. MOTHER'S MAIDEN NAME

Elizabeth Wells

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

215-32-3618

17. INFORMANT

ADDRESS

Records: BCH 4940 Eastern Ave. #21224

18. 4-22-11 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

cerebrovascular accident

INTERVAL BETWEEN
ONSET AND DEATH

3 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B) DUE TO

(C) DUE TO

ASCVD

years

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

pneumonia

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/5/66 to 12/14/66
that (I) (we) lost saw the deceased alive on 12/14/66 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Bruce M. Dow

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

12/14/66

23C. PHYSICIAN'S
NAME (Type)

Bruce M. Dow

M.D.

23D. ADDRESS

Baltimore, Maryland
4940 Eastern Avenue

#21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

12/20/66

24C. NAME of CEMETERY or CREMATORY

Arbutus Mem. Pk.

24D. LOCATION

Baltimore C. Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

Herbert E. Nutter-3035 W. North Ave.

DEC 16 1966

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66 12657

BIRTH NO. 66 12657

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Hicks, Walter

2. DATE AND HOUR OF DEATH

12/15/66 3:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)

33

The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

314 North Ann Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

4/19/19

9. AGE (In years last birthday)

47

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Salor

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Sterling Hicks

14. MOTHER'S MAIDEN NAME

Lucy Brown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

YES

16. SOCIAL SECURITY NO.

17. INFORMANT

Daisy Hicks

ADDRESS

Same

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

(B) DUE TO

(C)

hypertensive
encephalopathy

INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/11 1966 to 12/15 1966, that (I) (we) last saw the deceased alive on 12/15 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

David S. Fedson

M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

12/15/66

23C. PHYSICIAN'S NAME (Type)

David Fedson

M.D.

23D. ADDRESS

The Johns Hopkins Hospital

24A. BURIAL CREMATION REMOVAL (Specify)

Burial

24B. DATE

12-20-66

24C. NAME OF CEMETERY or CREMATORY

Balti Nat Bur

24D. LOCATION (City, town, or county) (State)

Balti Md

25A. DATE REC'D BY HEALTH DEPT.

DEC 10 1966

25B. NAME OF REGISTRAR

Robert E. Jackson

25C. FUNERAL DIRECTOR

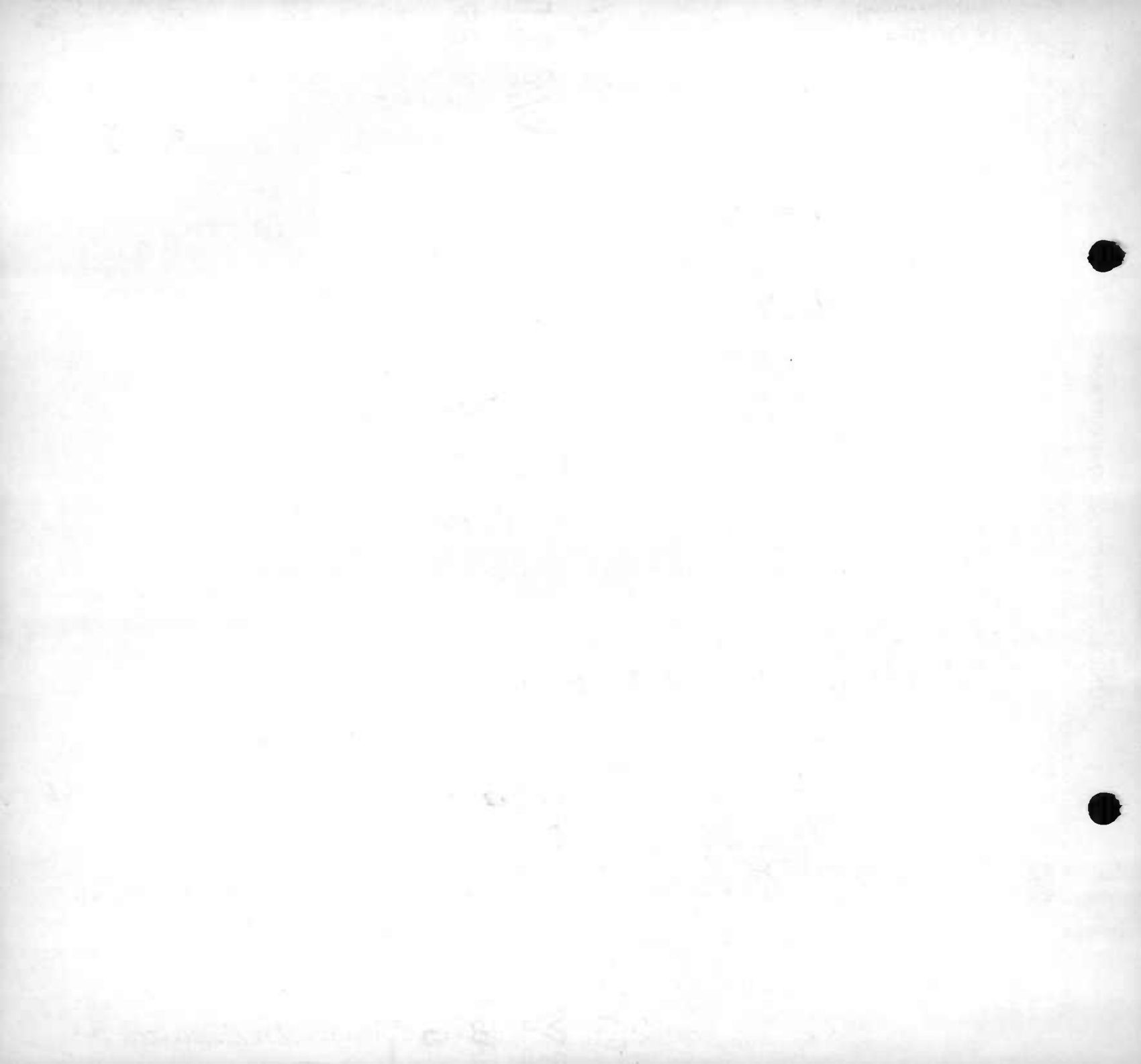
Elroy Wilson 100 Brantley Ave

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

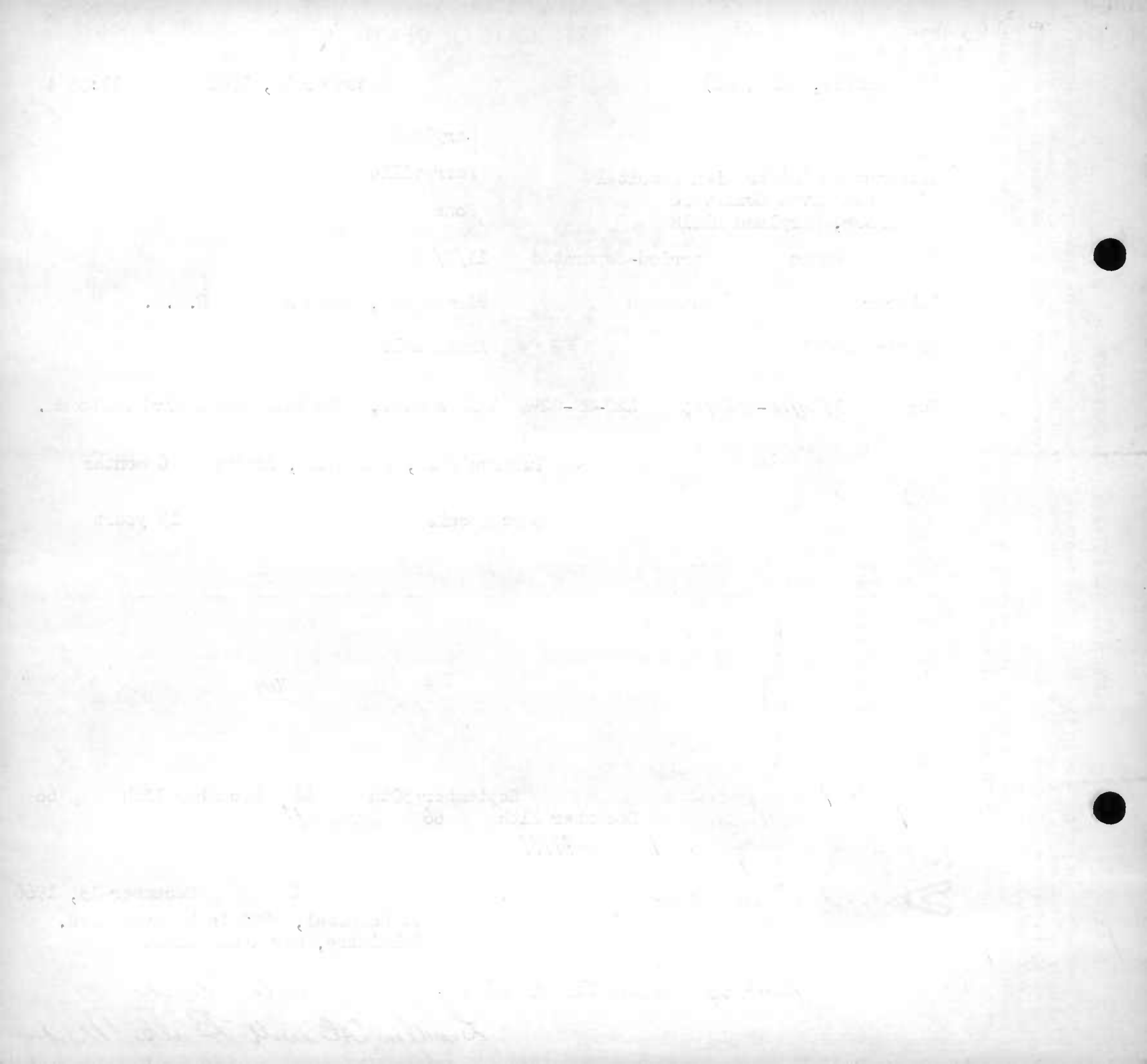
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------------|--|--|--|-------------------------------|
| BIRTH NO. 66 12658 | | BALTIMORE CITY HEALTH DEPARTMENT 66 12658 | | 66-12658-8 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | Registered No. JACKSON, JOSEPH A. | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| Joseph A. Jackson | | 12/16/66 | | 6:08 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital | | A. STATE Maryland | | B. COUNTY 9-09 | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | Baltimore | | | |
| D. STREET ADDRESS (If rural, give location) | | 1727 Acken Street | | AIKEN ST. | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days |
| Male | Negro | Single | 9/8/92 | 74 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? | |
| Factory | | | St Marys Co Md | USA | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| Napoleon | | Elzina Bryan | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT | | ADDRESS |
| No | | | Mamma Mary Hammond | | 1068 N Loyette St |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | | | |
| ANTECEDENT CAUSES | | Sepsis. | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CANCER ESOPHAGUS | | | |
| II | | (B) DUE TO | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (C) | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 12/13/66 | | CA Esophagus | YES | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 11/30 to 12/16/66 that (I) (we) last saw the deceased alive on 12/16/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | 23B. DATE SIGNED | | |
| W Stan Wilson | | | 12/16/66 | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| W Stan Wilson | | JWH | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY or CREMATORY | 24D. LOCATION (City, town, or county) | (State) | |
| Burial | 12-30-66 | Mt Auburn Cent | Balto Md | | |
| 25A. DATE REC'D BY HEALTH DEPT. | 25B. NAME OF REGISTRAR | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| DEC 19 1966 | Robert E. Seaborn | Eloy Wilson 1000 Braunty Ave | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|----------------------|--|---|---|---|--|---|--|---|
| 66 12659 | | | | | Registered No. 66 12659 | | | | |
| BIRTH NO. | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED (Type or Print) PRUITT, SAM (NMI) | | | | | 2. DATE AND HOUR OF DEATH December 11, 1966 11:55 A M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF (If not in hospital or institution, give street address or location) INSTITUTION Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218 | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Perryville D. STREET ADDRESS (If rural, give location) None | | | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married-Separated | 8. DATE OF BIRTH 11/2/24 | 9. AGE (In years last birthday) 42 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 11. BIRTHPLACE (State or foreign country) Birmingham, Alabama | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Dennis Pruitt | | | | | 14. MOTHER'S MAIDEN NAME Annie Hall | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1/29/44-1/12/45 | | | 16. SOCIAL SECURITY NO. 420-28-0294 | | 17. INFORMANT ADDRESS VAH Records, 3900 Loch Raven Blvd Balto Md. | | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Tuberculosis, Pulmonary, Active INTERVAL BETWEEN ONSET AND DEATH 6 months ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Sarcoidosis 13 years OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | |
| 20A. AUTOPSY? (Yes or No) Yes | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | |
| 21F. HOW DID INJURY OCCUR? | | | | | | | | | |
| 22. I certify that (1) (this hospital) attended the deceased from September 30th 19 66 to December 11th 19 66 , that (1) (we) last saw the deceased alive on December 11th 19 66 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <i>David H. Marine</i> | | | | | 23B. DATE SIGNED December 13, 1966 | | | | |
| 23C. PHYSICIAN'S NAME (Type) David H. Marine | | | | | 23D. ADDRESS VA Hospital, 3900 Loch Raven Blvd. Baltimore, Maryland 21218 | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 12/14/66 | | 24C. NAME of CEMETERY or CREMATORY Balta National | | | 24D. LOCATION (City, town, or county) (State) Balta Md | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 10 1966 | | 25B. NAME OF REGISTRAR John E. Taylor | | | 25C. FUNERAL DIRECTOR ADDRESS William H. Smith Balto Md. | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|---|---|--|--|
| BIRTH NO. 66 12660 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12660 | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) Henry J. BAUER, Sr. | | | December 16, 1966 1 7:35 A. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL | | | Maryland | | |
| 5. SEX Male | | | 6. RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married |
| 8. DATE OF BIRTH Sept. 14, 1903. | | | 9. AGE (In years last birthday) 63 | | 10. If Under 1 Yr. Months Days Hours Min. |
| 11. BIRTHPLACE (State or foreign country) Maryland | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME Henry J. Bauer | | | 14. MOTHER'S MAIDEN NAME Mary E. Nuth | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 215-09-6466 | | 17. INFORMANT Mrs. Marie L. Bauer |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 720.1 I CAUSE OF DEATH Sept Coronary Occlusion Coronary Sclerosis | | | INTERVAL BETWEEN ONSET AND DEATH 5 days | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/11/66 to 12/15/66 that (I) (we) last saw the deceased alive on 12/15/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Dr. Melvin F. Polek | | | | 23B. DATE SIGNED 12/16/66 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Melvin F. Polek | | | | 23D. ADDRESS 3603 Belair Rd., Baltimore Maryland | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/20/66. | | 24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery | |
| 24D. LOCATION Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. DEC 19 1966 | | | |
| 25B. NAME OF REGISTRAR Robert E. J. [unclear] | | 25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. 5305 Harford Rd. #14 | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 12661 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12661 | |
|---|--|---|--|--|--|---|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Carl J. Shaver | | | | 2. DATE AND HOUR OF DEATH December 17 1966 1 12 15 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | A. STATE Maryland | | B. COUNTY | |
| 3230 Kenyon Ave. | | 00 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | 26-03 | |
| 5. SEX Male | | 6. RACE White | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | | 8. DATE OF BIRTH 10/30/1911 | |
| 9. AGE (In years last birthday) 55 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Underwriter | | 10B. KIND OF BUSINESS OR INDUSTRY Insurance | | 11. BIRTHPLACE (State or foreign country) Harrisonburg Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Homer Proctor Shaver | | 14. MOTHER'S MAIDEN NAME Emma C. Miller | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | |
| 16. SOCIAL SECURITY NO. 215-01-3573 | | 17. INFORMANT Mrs. Martha Ross Shaver | | ADDRESS Same | | 18. CAUSE OF DEATH | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 163X I | | 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) II | | 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Secondary cerebral malnutrition | | INTERVAL BETWEEN ONSET AND DEATH 2 days | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) | |
| 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | 21G. DATE SIGNED | | 21H. DATE SIGNED | |
| 22. I certify that (I) (this hospital) attended the deceased from Nov 29 1966 to Dec 17 1966 , that (I) (we) last saw the deceased alive on Dec 17 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE Walter A. Anderson | | 23B. DATE SIGNED Dec 19-66 | | 23C. PHYSICIAN'S NAME (Type) Dr. Walter Anderson | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/21/66 | | 24C. NAME OF CEMETERY or CREMATORY Lake View Mem. Cem. | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 19 1966 | | 25B. NAME OF REGISTRAR Robert E. Feltman | | 25C. FUNERAL DIRECTOR Leonard J. Buck Inc. | | 25D. ADDRESS 5305 Harford Rd. | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12662 | |
|--|---------|--|------------------|--|-------------------------------|
| BIRTH NO. 66 12662 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| (Type or Print) Mae Cubbin, Mrs. Louise M. | | | | December 16, 1966 3:00 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | A. STATE | | B. COUNTY | |
| (If not in hospital or institution, give street address or location) | | Md. | | | |
| 37 Mercy Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | Baltimore #14 27-06 | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 5601 Birchwood Ave. | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months: Days |
| F | W | Widowed | April 7, 1885 | 81 | 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Housewife | | | | Baltimore, Md. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Ceprano Ferrandini | | Emily Ferceot | | USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| No | | 212-22-6496 | | Mr. John MacCubbin | |
| | | | | ADDRESS (Same) | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) Renal Failure | | at least 2 Ws | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) Carcinoma of Rectum and Anus | | at least 4 Ms | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Anemia | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| Dec. 6, 1966 | | Colostomy | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (this hospital) attended the deceased from | | November 23 1966 to December 16 1966 | | | |
| that (we) last saw the deceased alive on | | December 16 1966 and that in (our) opinion death occurred on the date | | | |
| and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| Yingling Lin | | | | December 16, 1966 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Yingling Lin | | Mercy Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 12/19/66. | | Parkwood Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State) | |
| | | | | Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| DEC 19 1966 | | P. J. J. J. J. | | Leonard J. Ruck, Inc. Balto. Md. 21214 | |

VS 150-REV. 1/1/69

12/10/00

MARTIN

12/10/00

MICROPHONE INFORMATION

NO

12-10-00

2nd D. K.

12/10/00

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|--|--|--|---------------------------------------|
| 66 12664 | | BALTIMORE CITY HEALTH DEPARTMENT | | 66 12664 | |
| BIRTH NO. | | M.E. CASE NO. | | Registered No. | |
| 1. NAME OF DECEASED (Type or Print) | | HENRY N. CONSTANTINE | | 2. DATE AND HOUR OF DEATH December 18, 1966 12.35 a.m. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | Maryland | | | |
| 90 GOULD CONVALESARIUM 6116 Belair Road | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 8-01 | | | |
| | | D. STREET ADDRESS (If rural, give location) 3229 Elmora Ave. | | | |
| 5. SEX male | 6. RACE white | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | | 8. DATE OF BIRTH 2/5/1885 | 9. AGE (In years last birthday) 81 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk | | 10B. KIND OF BUSINESS OR INDUSTRY B. & O. R.R. | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME Henry Constantine | | 14. MOTHER'S MAIDEN NAME Lucretia Nagel | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Emma C. Constantine | |
| | | | | ADDRESS Same | |
| 18. 332X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Advanced generalised arterio sclerosis (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 10 years | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Cerebral Thrombosis | | 1 month | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 10 - 1 1956 to 12 - 16 1966, that (I) (we) last saw the deceased alive on 12 - 16 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Milton C. Lang | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 12-19-66 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Milton C. Lang | | 23D. ADDRESS M.D. 2117 Belair Road, Baltimore, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/21/66 | | 24C. NAME of CEMETERY or CREMATORY Lorraine Park Cem. | |
| | | | | 24D. LOCATION (City, town, or county) (State) Woodlawn, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 19 1966 | | 25B. NAME OF REGISTRAR E. J. Lang | | 25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc.-Baltimore, Md.-14 | |
| | | | | ADDRESS | |

H-223

66 12665

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12665

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN E.

Hochstedt

~~HOCHSTEDT~~

2. DATE AND HOUR PRONOUNCED DEAD

December 18, 1966

7:50 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore #34

27-05

D. STREET ADDRESS (If rural, give location)

6931 Harford Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Divorced

8. DATE OF BIRTH

Oct. 30, 1920.

9. AGE (In years
last birthday)

46

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Lieut.

10B. KIND OF BUSINESS OR INDUSTRY

Balto. Fire Dept.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Charles Hochstedt

14. MOTHER'S MAIDEN NAME

Henrietta Burgan

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give year or dates of service)

Yes

WW2

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Elizabeth A. Barry, Annapolis Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/18/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/21/66.

23C. NAME of CEMETERY or CREMATORY

Meadowridge Mem. Cemetery

23D. LOCATION

(City, town, or county)

Dorsey, Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

DEC 18 1966

Leonard J. Ruck, Inc. Balto. Md. 21214

MAILED FOR FILE

RECEIVED
JAN 20 1980
FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE
WASHINGTON, D.C. 20535

TO : DIRECTOR, FBI

FROM : SAC, NEW YORK (100-100000)

SUBJECT: [Illegible]

M-424

66 12666

BALTIMORE CITY HEALTH DEPARTMENT

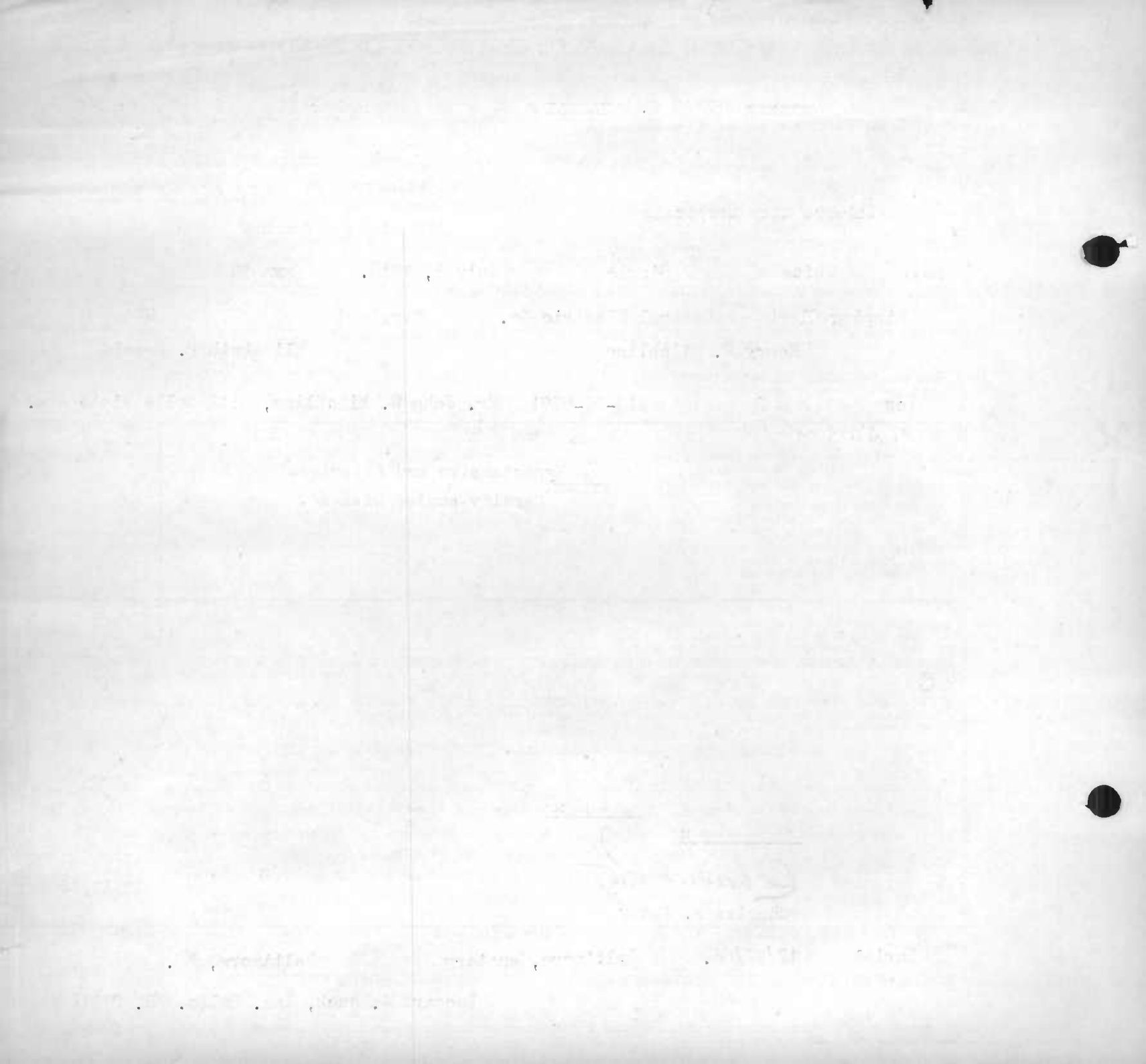
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 12666

BIRTH NO.

M.E. CASE NO.

| | | | | | | | |
|---|-------------------------|--|--|---|--|--|----------------------------------|
| 1. NAME OF DECEASED (Type or Print) HERMAN C. MILCHLING | | | | 2. DATE AND HOUR PRONOUNCED DEAD December 18, 1966 6:25 A M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore #6 26-01 D. STREET ADDRESS (If rural, give location) 5917 Cedonia Avenue | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH July 5, 1916. | 9. AGE (In years last birthday) xxx 50 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping Clerk | | 10B. KIND OF BUSINESS OR INDUSTRY General Electric Co. | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Henry F. Milchling | | | | 14. MOTHER'S MAIDEN NAME Elizabeth F. Besold | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 2 | | 16. SOCIAL SECURITY NO. 215-09-8791 | | 17. INFORMANT ADDRESS Mr. John H. Milchling, 6512 Belle Vista Ave. | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive and Arteriosclerotic Cardiovascular Disease. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Petty M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Petty ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 12/18/66 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 12/22/66. | | 23C. NAME of CEMETERY or CREMATORY Baltimore Cemetery | | 23D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 24A. DATE REC'D BY HEALTH DEPT. DEC 18 1966 | | 24B. NAME OF REGISTRAR Robert E. Feltner | | 24C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc. Balto. Md. 21214 | | | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

AGNES

EWING

2. DATE AND HOUR PRONOUNCED DEAD

December 17, 1966

9:51 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 4404 Marble Hall Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore #18 27-09

D. STREET ADDRESS (If rural, give location)

4404 Marble Hall Road

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

Sept. 25, 1895.

9. AGE (In years
last birthday)

71

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Social Security

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Charles Nohe

14. MOTHER'S MAIDEN NAME

Walburga Keltner

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Lt. Col. Wm. Ewing, Augusta, Ga.

18. E9030

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Pulmonary embolism
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Thrombosis of left leg veins
DUE TO

(C) Fracture of bones of left ankle

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? Yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

home

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

4404 Marble Hall Rd. 27-09

21D. TIME
OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.)

Oct. 27, 1966 a.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

tripped over sill and fell

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/17/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/21/66.

23C. NAME of CEMETERY or CREMATORY

Holy Redeemer Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

DEC 19 1966

24B. NAME OF REGISTRAR

Robert E. Fadden

24C. FUNERAL DIRECTOR

Leonard J. Ruck, Inc. Balto. Md. 21214

ADDRESS

WILFRED HODGE

WILFRED HODGE

66 12668

BALTIMORE CITY HEALTH DEPARTMENT

66 12668

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM E. LAUMANN, Sr.

2. DATE AND HOUR PRONOUNCED DEAD

December 17, 1966 12:50 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 2924 Glenmore Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore #14 27-06

D. STREET ADDRESS (If rural, give location)

2924 Glenmore Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)
Married

8. DATE OF BIRTH

May 16, 1893.

9. AGE (In years
last birthday)

73

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

City Of Baltimore

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Henry Laumann

14. MOTHER'S MAIDEN NAME

Ada Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.
220-32-3143

17. INFORMANT

Mrs. Mary Lou Laumann

ADDRESS

(Same)

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/17/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/20/66.

23C. NAME of CEMETERY or CREMATORY

Dulaney Valley Mem. Cem.

23D. LOCATION (City, town, or county) (State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

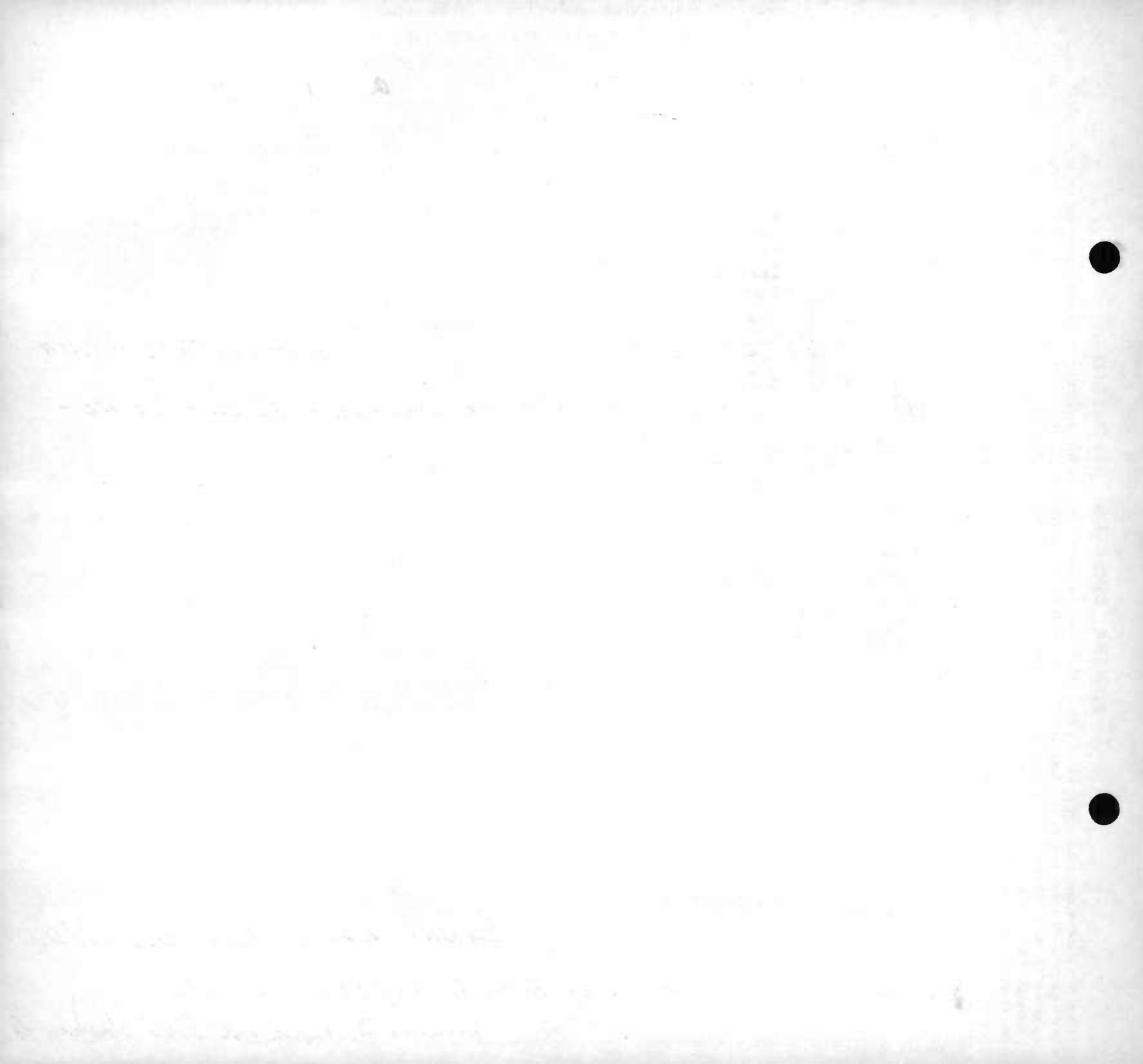
Leonard J. Ruck, Inc. Balto. Md. 21214

MALIBY POND

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

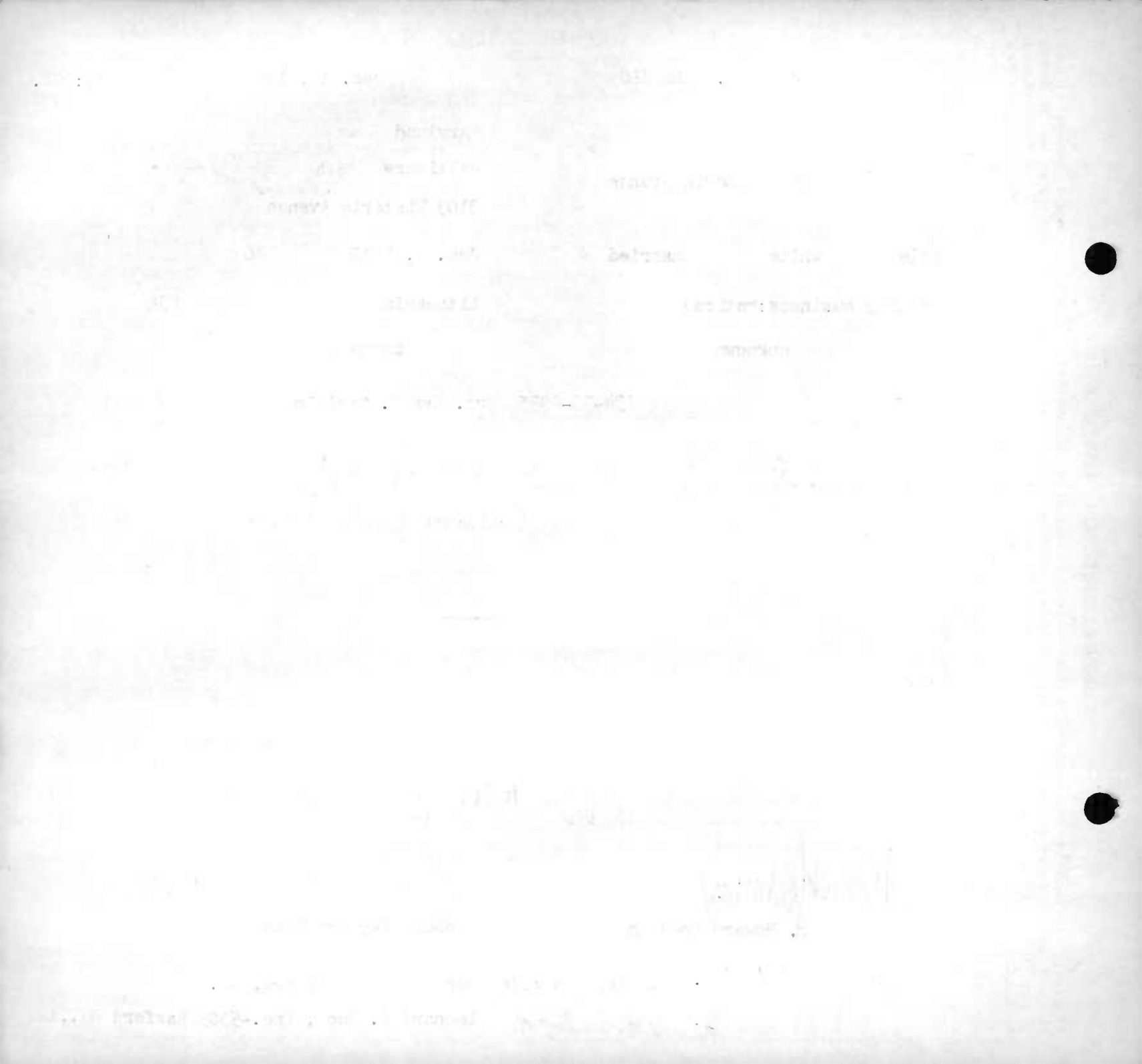
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|---|---------|--|--|--|------------------------------|
| 66 12669 | | 66 12669 | | | |
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| | | ROUCH, NETTIE G. | | 2:30 AM DEC. 17, 1966 M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| SINAI HOSPITAL OF BALTIMORE, INC. | | A. STATE MARYLAND | | | |
| 42 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | BALTIMORE 27-01 | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 3509 AILSA AVE # 14 | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. CITIZEN OF WHAT COUNTRY? |
| FEMALE | WHITE | MARRIED | 10/29/10 | 36 | U. S. A. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
| HOUSEWIFE | | | | MARYLAND | U. S. A. |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| WAITER HUGHES | | | ELIZABETH BALDWIN | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | 212-09-8281 | | MR. LAWRENCE L. ROUCH - SAME - | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | CAUSE OF DEATH | | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | (A) ELECTROLYTE IMBALANCE, PISTULA FORMATION | | |
| ANTECEDENT CAUSES | | | (B) DUE TO GENERALIZED DEBILITY, TOXIC MEGACOLON | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (C) (POST-OP) ULCERATIVE COLITIS W/PERFORATION | | |
| | | | (D) DUE TO PHLEBOTROMBOSIS | | |
| | | | (E) W/TERMINAL ILEOSTOMY | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 11/2/66 | | ULCERATIVE COLITIS W/PERFORATION | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/22 19 66 to 12/17 19 66, that (I) (we) last saw the deceased alive on 12/17 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Rynall P. Hadrian M.D. | | | | 12/17/66 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| | | SINAI HOSP BALTIMORE MD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 12/19/66 | | GARDENS of FAITH Cemetery Baltimore MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| DEC 19 1966 | | A. J. E. Johnson | | LEONARD J. RUCK INC-5305 Harbor Rd. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

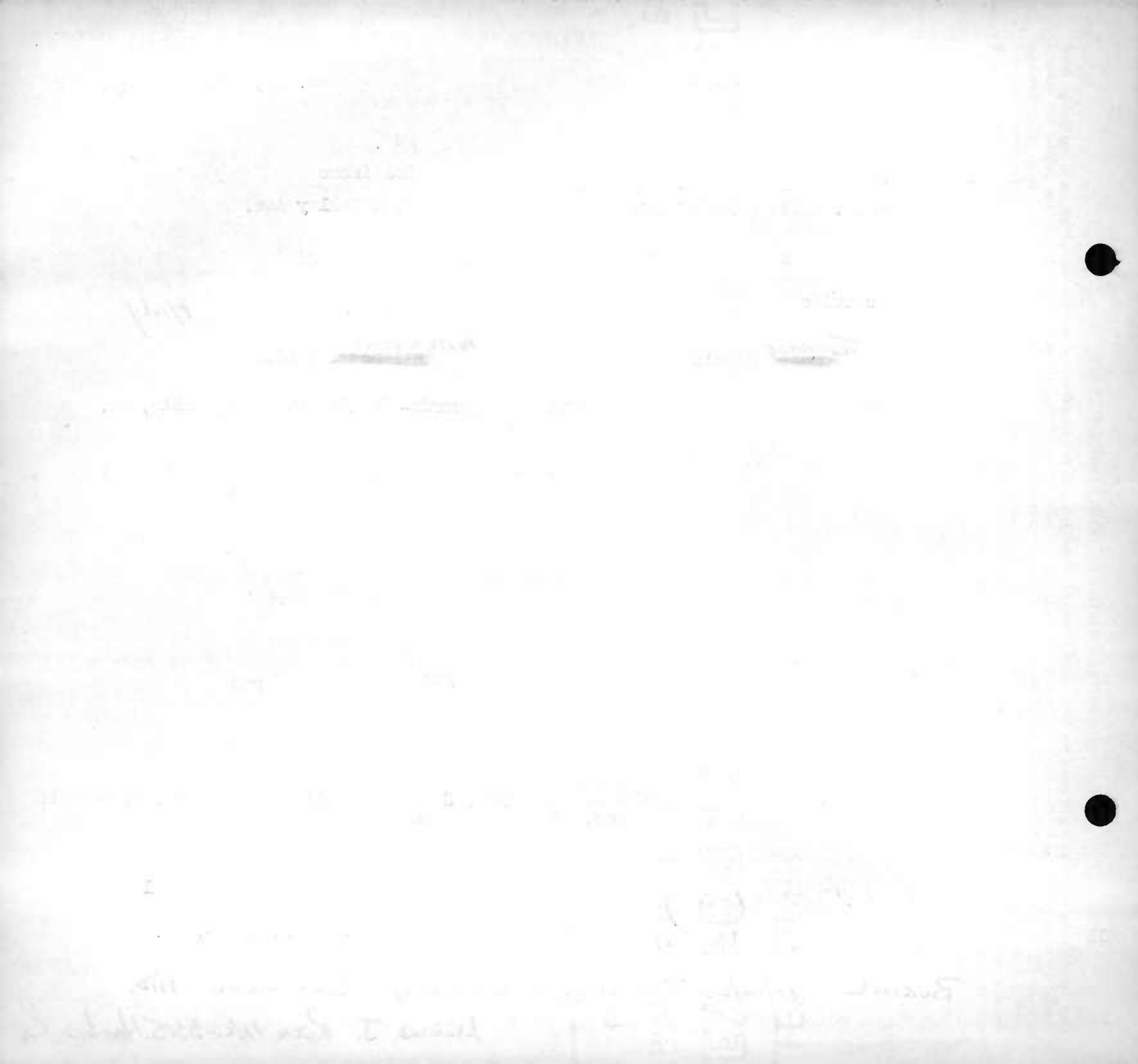
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 12670</u> | |
|--|-------------------------|--|---|---|---|
| BIRTH NO. <u>66 12670</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) JOHN W. DANIELS | | 2. DATE AND HOUR OF DEATH Dec. 16, 1966 11:20P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3103 Wisteria Avenue | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #14 27-44 D. STREET ADDRESS (If rural, give location) 3103 Wisteria Avenue | | |
| 5. SEX male | 6. RACE white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married | 8. DATE OF BIRTH Jan. 1, 1880 | 9. AGE (In years last birthday) 86 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clothing business: retired | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Lithuania | |
| 13. FATHER'S NAME unknown | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 134-03-0935 | | 17. INFORMANT Mrs. Eva M. Daniels |
| 18. <u>199.21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | CAUSE OF DEATH (A) <u>Carcinoma, Genital</u> DUE TO (B) <u>Carcinoma, prostate gland</u> DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH 3 mm 19 hr |
| 19A. DATE OF OPERATION <u>10 Dec</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>10 Dec</u> <u>1966</u> to <u>16 Dec</u> <u>1966</u> , that (I) (we) last saw the deceased alive on <u>15 Dec</u> <u>1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Howard Goodman</i> | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 17 Dec 66 |
| 23C. PHYSICIAN'S NAME (Type) Dr. Howard Goodman | | | 23D. ADDRESS 8604 Harford Road | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) burial | | 24B. DATE 12/20/66. | | 24C. NAME of CEMETERY or CREMATORY Moreland Memorial Park | |
| 24D. LOCATION Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. DEC 19 1966 | | | |
| 25B. NAME OF REGISTRAR Leonard J. Ruck, Inc. | | 25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. - 5305 Harford Rd., 14 | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RGB

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | | | | | |
|---|--|--------------|--|---|---|-----------------------------|--|---------------------------------------|--|---|--|-----------------------|--|--|---|--|--|--|--|
| BIRTH NO. 66 12671 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 66 12671 | | | | | | | | | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Anna Anderson | | | | | 2. DATE AND HOUR OF DEATH Dec. 16, 1966 5:55 P M. | | | | | | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Public Health Service Hospital Wyman Pk. Drive & 31st Street | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2902 Oakley Ave. | | | | | | | | | | | | | | |
| 5. SEX F | | 6. RACE W | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | | 8. DATE OF BIRTH 3/20/20 | | 9. AGE (In years lost birthday) 46 | | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. | | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | | 11. BIRTHPLACE (State or foreign country) Italy | | | | | 12. CITIZEN OF WHAT COUNTRY? Italy | | | | |
| 13. FATHER'S NAME Tommaso Riccio | | | | | 14. MOTHER'S MAIDEN NAME Antonietta Nobile | | | | | | | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | | 16. SOCIAL SECURITY NO. None | | | | | 17. INFORMANT Records- US PHS Hospital, Balto, Md. | | | | | ADDRESS | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osleria, etc. It means the disease, injury or complication which caused death.) Adenocarcinoma of Lung DUE TO | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH months | | | | | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | | | | | | | | | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION 2 | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20A. AUTOPSY? (Yes or No) yes | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Nov. 8 1966 to Dec. 16 1966, that (I) (we) last saw the deceased alive on Dec. 16 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 23A. SIGNATURE M.D. Bellamy | | | | | | | | | | 23B. DATE SIGNED 12/17/66 | | | | | | | | | |
| 23C. PHYSICIAN'S NAME (Type) M.D. Bellamy | | | | | 23D. ADDRESS M.D. US PHS Hospital, Balto, Md. | | | | | | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | | | 24B. DATE 12/20/66 | | | | | 24C. NAME OF CEMETERY or CREMATORY BALTIMORE NATL. CEMETERY | | | | | 24D. LOCATION (City, town, or county) (State) BALTIMORE MD. | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 19 1966 | | | | | 25B. NAME OF REGISTRAR Robert E. Talley | | | | | 25C. FUNERAL DIRECTOR LEONARD J. ROCK INC.-5305 HARTO RD | | | | | ADDRESS | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|---------------------|--|--|---|---|--|--|
| BIRTH NO. 66 12672 | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 66 12672 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type, or Print) McGUIRE, MARY HELENE | | | | 2. DATE AND HOUR OF DEATH 12-14-66 3:50 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4 UNION MEMORIAL HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY BALTIMORE | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE, 18, 12-02 | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 3501 ST. PAUL ST. APT. 1049 | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED | | 8. DATE OF BIRTH 02-02-82 | 9. AGE (In years lost birthday) 84 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE RETIRED | | 10B. KIND OF BUSINESS OR INDUSTRY WESTERN MD. RAILWAY | | 11. BIRTHPLACE (State or foreign country) KEYSER W.VA. MARLAND | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME THOMAS V. McGUIRE | | | | 14. MOTHER'S MAIDEN NAME MARY MURPHY | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT MRS. VIRGINIA F. BROWN ADDRESS MIAMI, FLA. 2300 S.W. 18th AVE. 33145 | |
| 18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) ASCVD DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH unk | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) no | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) none | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (H) (this hospital) attended the deceased from 13 Dec 1966 to 14 Dec 1966 , that (I) (we) last saw the deceased alive on 14 Dec 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Sidney E. Kirkley | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 14 Dec. 66 | |
| 23C. PHYSICIAN'S NAME (Type) SIDNEY E. KIRKLEY, M.D. | | | | 23D. ADDRESS THE UNION MEMORIAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/19/1966 | | 24C. NAME of CEMETERY or CREMATORY New Cathedral | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 19 1966 | | 25B. NAME OF REGISTRAR E. Jenkins | | 25C. FUNERAL DIRECTOR ADDRESS H. W. Jenkins & Sons Co. 4905 York Rd. Baltimore 12, Md. | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|------------------|--|-----------------------------|--|---|
| BIRTH NO. 66 12673 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12673 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) William Barton Bayrle | | 2. DATE AND HOUR OF DEATH 12-16-66 8:13 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. - B. COUNTY Baltimore | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hosp. 44 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 9-03 | | | |
| | | D. STREET ADDRESS (If rural, give location) 3603 Kimble Rd. | | | |
| 5. SEX M | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH 2-23-23 | 9. AGE (in years last birthday) 43 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MOVIE INSPECTOR | | 10B. KIND OF BUSINESS OR INDUSTRY STATE CENSOR BOARD | | 11. BIRTHPLACE (State or foreign country) Maryland. | |
| 12. CITIZEN OF WHAT COUNTRY? (America) USA | | 13. FATHER'S NAME WILLIAM CARL BAYRLE | | 14. MOTHER'S MAIDEN NAME CAMERON FITZHUGH | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW II | | 16. SOCIAL SECURITY NO. 218-12-7464 | | 17. INFORMANT 1120 E. 36th St. FRANKLIN W. ASICHEMEIER, JR. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Pulmonary edema | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO Hypertensive CVD | | INTERVAL BETWEEN ONSET AND DEATH 2 hr | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypertension, emphysema, gout | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) no | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 16 Dec 1966 to 16 Dec 1966, that (I) (we) last saw the deceased alive on 16 Dec 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Sidney E. Kuhley | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 16 Dec. 66 | |
| 23C. PHYSICIAN'S NAME (Type) Sidney E. Kuhley | | M.D. ADDRESS Union Memorial Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/20/1966 | | 24C. NAME of CEMETERY or CREMATORY Loudon Park | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. DEC 19 1966 | | 25B. NAME OF REGISTRAR R. E. Jenkins | |
| 25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. | | ADDRESS 4905 York Rd. Baltimore 12, Md. | | | |

James Earl Ray

12-11-68

Mo.

Baltimore

3603 Kimple Rd.

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Maryland

Amesbury

James Earl Ray

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MOBILE INSPECTOR

Department of
Public Safety

Department of Public Safety

Richard E. Kimple

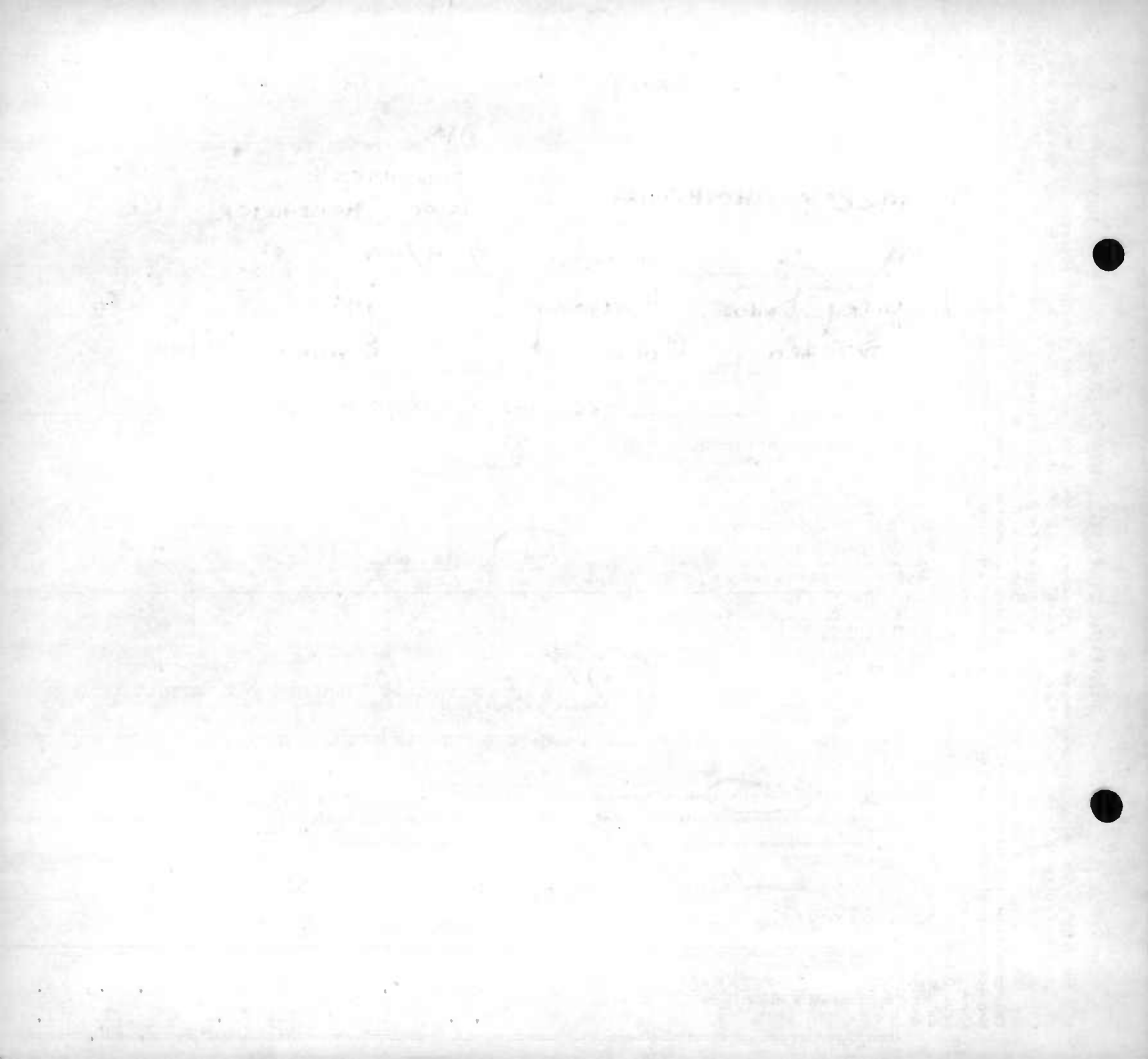
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

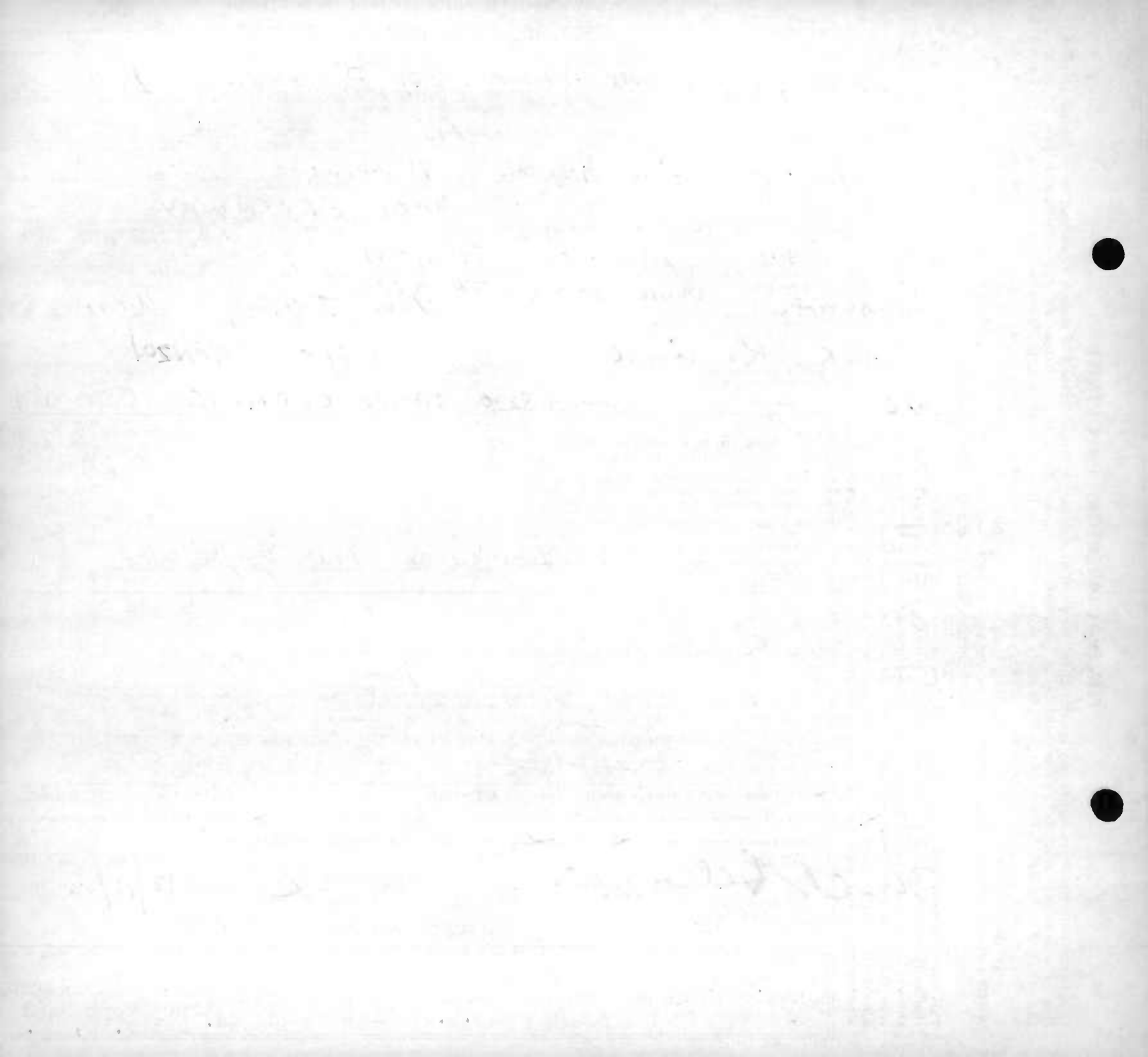
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 12674</u> | |
|--|--|---|--|---|--|
| BIRTH NO. <u>66 12674</u> | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Mr. S. Leroy Cole</u> | | 2. DATE AND HOUR OF DEATH <u>12-18-66</u> <u>8⁰⁵ P.M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>37 MERCY HOSPITAL</u> | | (If not in hospital or institution, give street address or location) | | A. STATE <u>Md.</u> B. COUNTY | |
| 5. SEX <u>M</u> | | 6. RACE <u>N</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | |
| 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u> | | 8. DATE OF BIRTH <u>4-27-09</u> | | 9. AGE (In years last birthday) <u>57</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laundry Owner</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Laundry</u> | | 11. BIRTHPLACE (State or foreign country) <u>Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u> | | 13. FATHER'S NAME <u>Stephen Cole</u> | | 14. MOTHER'S MAIDEN NAME <u>Emma Stein</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>218-26-7721</u> | | 17. INFORMANT <u>E. VIRGINIA COLE (SAME)</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) <u>Ca of Pancreas</u> | | 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Duodenal Ulcer</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>Months</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>7-7-66</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Ca of Pancreas</u> | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12-18</u> 19 <u>66</u> to <u>12-18</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12-18</u> 19 <u>66</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Eldon Hawbaber, M.D.</u> | | | | 23B. DATE SIGNED <u>12-18-66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Eldon Hawbaber</u> | | 23D. ADDRESS <u>Mercy Hospital</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12/21/1966</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Moreland Memorial Pk. Parkville, Balto. Co., Md.</u> | |
| 24D. LOCATION (City, town, or county) (State) | | 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 19 1966</u> | | | |
| 25B. NAME OF REGISTRAR <u>H. W. Jenkins & Sons Co.</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>4905 York Rd. Baltimore 12, Md.</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 66 12675 | |
|---|---------|--|------------------|---|---|--|--|
| BIRTH NO. 66 12675 | | M.E. CASE NO. | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| | | | | DAVIS, HELEN (MAIDEN NAME - GAND) | | 12-18-66 1:45 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | |
| 48 MARYLAND GEN. Hospital | | | | Md. Baltimore | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | | | Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | | |
| | | | | 3401 GREENWAY | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | |
| FEM. | CAUC. | MARRIED | 04-21-91 | 75 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Housewife | | OWN HOME | | TRENTON, NEW JERSEY | | U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| FRANK K. GAND | | | | Emilie WENZEL | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| NO | | 214-24-8220 | | JAMES O. DAVIS | | (SAME) | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | (A) DUE TO | | 3 DAYS | |
| ANTECEDENT CAUSES | | | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) LEUKEMIA, Acute Lymphoblastic | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| None | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| None | | | | No | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | | (If in Baltimore City, give exact location) | |
| No | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (this hospital) attended the deceased from 12-15 19 66 to 12-18 19 66, that (I) last saw the deceased alive on 12-17 19 66 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| [Signature] | | | | 12/18/66 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | 23E. FUNERAL DIRECTOR | | ADDRESS | |
| Ronald Goldman | | Maryland General Hospital | | H.W. Jenkins & Sons Co. | | 4905 York Road Balto. 12, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 12/21/1966 | | West Long Branch | | West Long Branch, New Jersey | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| DEC 19 1966 | | [Signature] | | H.W. Jenkins & Sons Co. | | 4905 York Road Balto. 12, Md. | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 12676 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12676 | |
|---|---------------------|---|---|--|-------------------------------|--|--|
| 1. NAME OF DECEASED (Type or Print) <i>Anna Neumann</i> | | | | 2. DATE AND HOUR OF DEATH <i>12.17.66</i> <i>5</i> <i>45</i> <i>P.</i> <i>M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>90 Little Srs. of The Poor</i> <i>1200 Valley St</i> <i>BALT. MO 21202</i> | | (If not in hospital or institution, give street address or location) | | A. STATE <i>MD</i> | | B. COUNTY | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALT.</i> <i>10-01</i> | | | |
| | | | | D. STREET ADDRESS (If rural, give location) <i>1200 Valley St.</i> | | | |
| 5. SEX <i>F</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH <i>May 27, 1874</i> | 9. AGE (In years last birthday) <i>92</i> | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housekeeper</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>BALTIMORE</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>Adam Neumann</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Cecilia Roemelt</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i> | | 16. SOCIAL SECURITY NO. <i>213-54-2844</i> | | 17. INFORMANT <i>Little Srs. of The Poor</i> | | ADDRESS | |
| 18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Acute Myocardial infarct</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Generalized arteriosclerosis</i> <i>Senile</i> | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>1965</i> to <i>Dec. 17, 1966</i> , that (I) (we) last saw the deceased alive on <i>Dec. 17, 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Stanley Ankudus</i> | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>12.19.66.</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>STANLEY Ankudus</i> | | | | 23D. ADDRESS <i>1101 Maiden Choice Lane</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12/20/66</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Cathedral Cem.</i> | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 19 1966</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Tolson</i> | | 25C. FUNERAL DIRECTOR <i>Philip Herwig Sons</i> | | ADDRESS <i>2024 Orleans St</i> | |

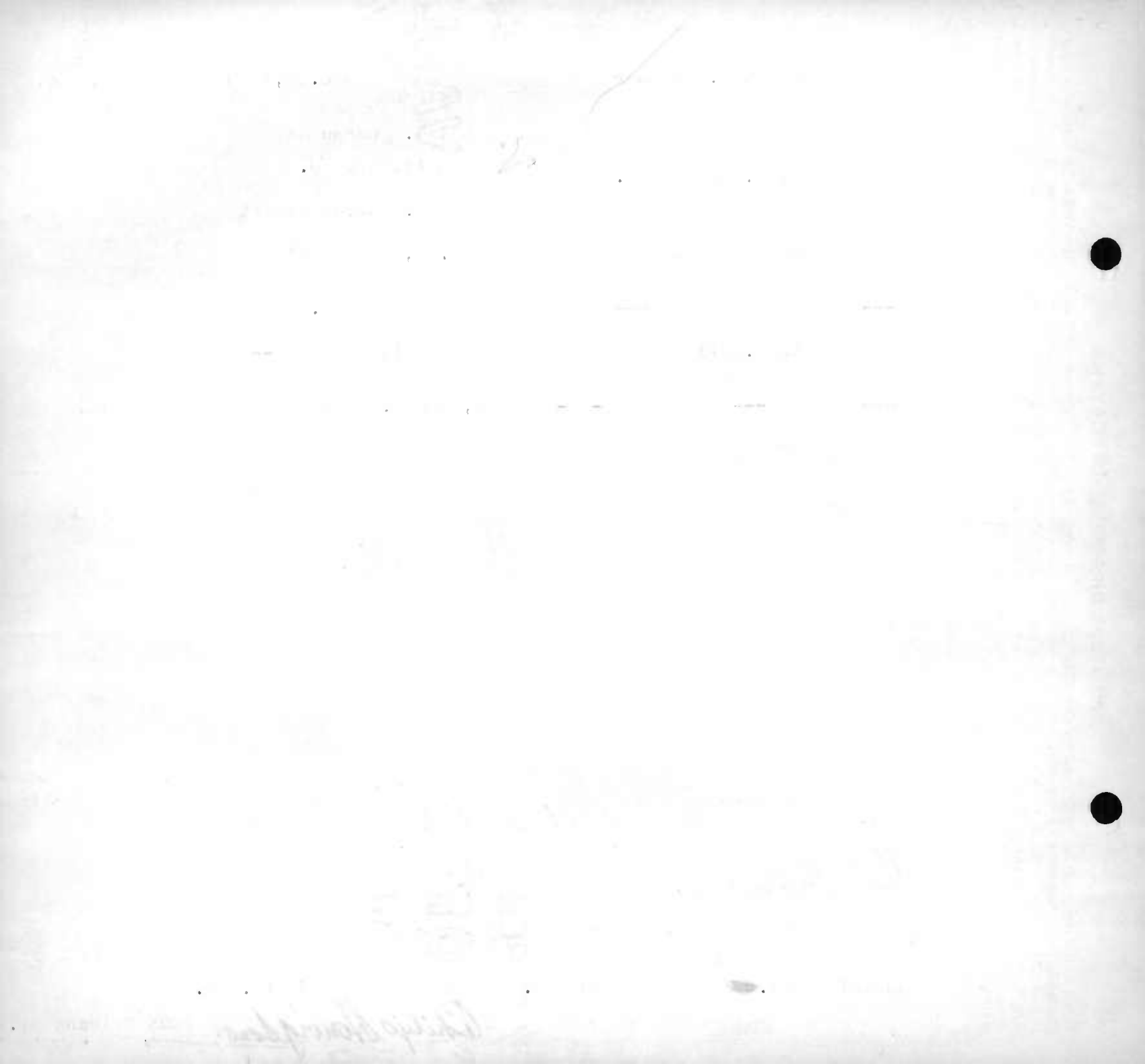
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | Registered No. 66 12677 | |
|--|--------------|---|--|--|---|
| <div style="display: flex; justify-content: space-between;"> BIRTH NO. 66 12677 CERTIFICATE OF DEATH </div> | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) Mrs Anna Krauth | | | 2. DATE AND HOUR OF DEATH 2:45 AM 12/19/66 M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland General Hosp | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 8-02 | | |
| D. STREET ADDRESS (If rural, give location) 2122 Federal St. | | | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M | 8. DATE OF BIRTH 6/17/07 | 9. AGE (In years last birthday) 59 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Germany | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Adam Kengel | | | 14. MOTHER'S MAIDEN NAME Schultz, Maureen | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) — | | 16. SOCIAL SECURITY NO. 215-03-9880 | | 17. INFORMANT Clara | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 214 X I (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) Acute heart failure DUE TO (B) Septic shock DUE TO (C) Bacteremia | | INTERVAL BETWEEN ONSET AND DEATH 4 hours |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION Excision, cervix | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fibroid Cervical | | 20A. AUTOPSY? (Yes or No) no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 12/12/66 to 12/19/66, that (2) (we) last saw the deceased alive on 12/19/66 and that (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Blair C. Wilkerson | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/19/66 |
| 23C. PHYSICIAN'S NAME (Type) Daniel C Wilkerson | | | 23D. ADDRESS 421 Regester Ave | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Buried | | 24B. DATE Dec 22/66 | | 24C. NAME OF CEMETERY or CREMATORY Holy Redeemer | |
| 24D. LOCATION (City, town, or county) Baltimore | | 24E. (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 19 1966 | | 25B. NAME OF REGISTRAR E. E. E. | | 25C. FUNERAL DIRECTOR Philip Herwig Sons Orleans St | |
| 25D. ADDRESS 2024 | | | | | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 12678 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12678 | |
|--|-------------------------|---|--|--|--|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Margaret S. Greiner | | | | 2. DATE AND HOUR OF DEATH Dec. 18, 1966 6 ³⁰ A. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | A. STATE | | B. COUNTY | |
| <div style="font-size: 2em; margin-bottom: 10px;">00</div> 631 N. Duncan St. | | 631 N. Duncan St. Baltimore Md. 631 N. Duncan Street | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | 5 | |
| | | | | D. STREET ADDRESS (If rural, give location) | | 7-03 | |
| | | | | | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow | 8. DATE OF BIRTH Nov. 11, 1885 | 9. AGE (In years last birthday) 81 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| --- | | --- | | Baltimore Md. | | | |
| 13. FATHER'S NAME John H. Keil | | | | 14. MOTHER'S MAIDEN NAME Elizabeth -- | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 215-12-1299 | | 17. INFORMANT Mr. John H. Keil | | ADDRESS 3428 Juneway (13) | |
| --- | | --- | | | | | |
| 18. 4201 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) DUE TO Coronary Thrombosis | | 1 day | |
| | | | | (B) DUE TO Hypertension C.V.D. | | 11/7/61 | |
| | | | | (C) DUE TO Arthritis | | ? | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 11/17 19 61 to 12/18 19 66 , that (I) last last saw the deceased alive on 12/16 19 66 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Louis F. Kline | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) LOUIS F. KLINES | | | | 23D. ADDRESS 2623 E. Monument St. Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 21 Dec. 21/66 | | 24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cem. | | 24D. LOCATION (City, town, or county) Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 19 1966 | | 25B. NAME OF REGISTRAR P. E. E. Feltner | | 25C. FUNERAL DIRECTOR Philip Hewigsons | | ADDRESS 2024 Orleans St. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. <u>66 12679</u> | |
|--|---------------------|---|--|--|--|---|--------------------------------|
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Earl J. Boram, Sr.</u> | | 2. DATE AND HOUR OF DEATH <u>December 19, 1966</u> <u>2:00</u> <u>A.M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>35 Church Home & Hospital</u> | | (If not in hospital or institution, give street address or location) | | A. STATE <u>Maryland</u> | | B. COUNTY | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | | |
| | | | | D. STREET ADDRESS (If rural, give location) <u>113 N. Decker Avenue</u> | | | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u> | | 8. DATE OF BIRTH <u>7/20/'07</u> | 9. AGE (In years lost birthday) <u>59</u> | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Operator Service Station</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Albert M. Boram</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Anna Olt</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Mrs. Beatrice V. Boram</u> <u>113 N. Decker Ave.</u> | | | |
| 18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) <u>acute myocardial infarction</u> DUE TO (B) <u>Arterial CVD disease</u> DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>5 yr</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION <u>None</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12/19</u> <u>1966</u> to <u>12/19</u> <u>1966</u> that (I) (we) lost saw the deceased alive on <u>12/19</u> <u>1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Mamie Filburn</u> | | | | | | 23B. DATE SIGNED <u>12/19/66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/></u> | | | | | | 23D. ADDRESS <u>2 E Read St Baltimore</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12/21/'66</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Oak Lawn Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR <u>John A. Moran, Inc.</u> | | 25C. FUNERAL DIRECTOR | | ADDRESS <u>3000 E. Baltimore St.</u> | |

1
L-521

66 12680

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12680

BIRTH NO.

M.E. CASE NO.

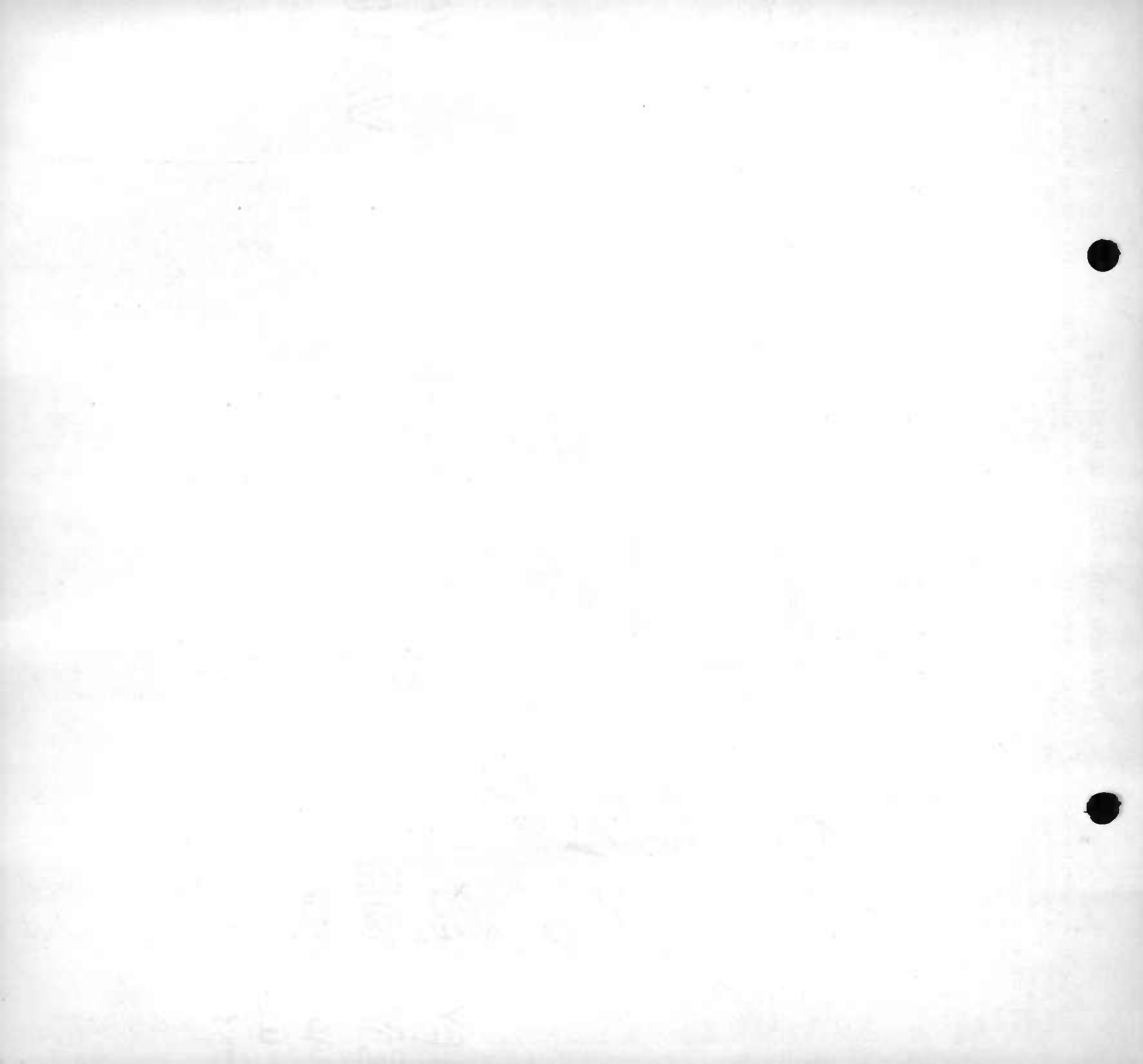
| | | | |
|--|--|--|---|
| 1. NAME OF DECEASED (Type or Print) HELEN M. LANGFORD | | 2. DATE AND HOUR PRONOUNCED DEAD December 10, 1966 3:20 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1012 E. North Avenue | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside corporate limits, with RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1012 E. North Avenue | |
| 5. SEX Female | 6. RACE Colored | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed | 8. DATE OF BIRTH Sept 20, 1897 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | 10B. KIND OF BUSINESS OR INDUSTRY Private Family | 9. AGE (In years last birthday) 69 |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Charles Wise | | 14. MOTHER'S MAIDEN NAME Ann Boyer | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 219-22-7855 | |
| 17. INFORMANT Mr. Ernest Watkins | | ADDRESS 3602 Reisterstown Rd | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive Cardiovascular Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Diabetes Mellitus OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | INTERVAL BETWEEN ONSET AND DEATH |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) | |
| 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Rudiger Breitenecker, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/11/66 | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | 23B. DATE Dec 14, 1966 | 23C. NAME OF CEMETERY or CREMATORY Mount Auburn Cemetery | 23D. LOCATION (City, town, or county) (State) Baltimore, Maryland |
| 24A. DATE REC'D BY HEALTH DEPT. DEC 13 1966 | 24B. NAME OF REGISTRAR Robert E. Johnson | 24C. FUNERAL DIRECTOR ADDRESS Herbert E. Nutter 3035 W. North Ave | |

[Handwritten signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------|--|---|---|---------------------------------|
| BIRTH NO. 66 12681 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12681 | |
| M.E. CASE NO. | | | | 1. NAME OF DECEASED | |
| (Type or Print) | | | | Lucy H. Bailey | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 2. DATE AND HOUR OF DEATH | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | 12/11/66 M. | |
| 00 2309 Roslyn Avenue | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | |
| | | | | A. STATE B. COUNTY | |
| | | | | Maryland | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| | | | | Baltimore | |
| | | | | D. STREET ADDRESS (If rural, give location) | |
| | | | | 2033 N. Fulton Ave. | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. If Under 1 Yr. Months Days |
| Female | Negro | WIDOWED, DIVORCED (specify) | 12/26/1882 | 83 | 11. If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Domestic Work | | Private Family | | Baltimore | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| ? | | | Charolett ? | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 17. INFORMANT ADDRESS | | |
| | | | Mr John Holbrook 2033 N. Fulton Ave. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | CAUSE OF DEATH | | |
| (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | | Arteriosclerotic Cardiovascular Disease | | |
| ANTECEDENT CAUSES | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from June 1966 to Sept 1966, that (I) (we) last saw the deceased alive on Sept 20 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Louis T. Lavy M.D. | | | | Dec 12 - 1966 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| LOUIS T. LAVY M.D. | | | | 1844 W. North Ave Baltimore Md | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 12/17/66 | | Arbutus Memorial Pk Baltimore Co, Md | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| DEC 19 1966 | | Robert E. Feltner | | Herbert E. Notter 3035 W North Ave | |



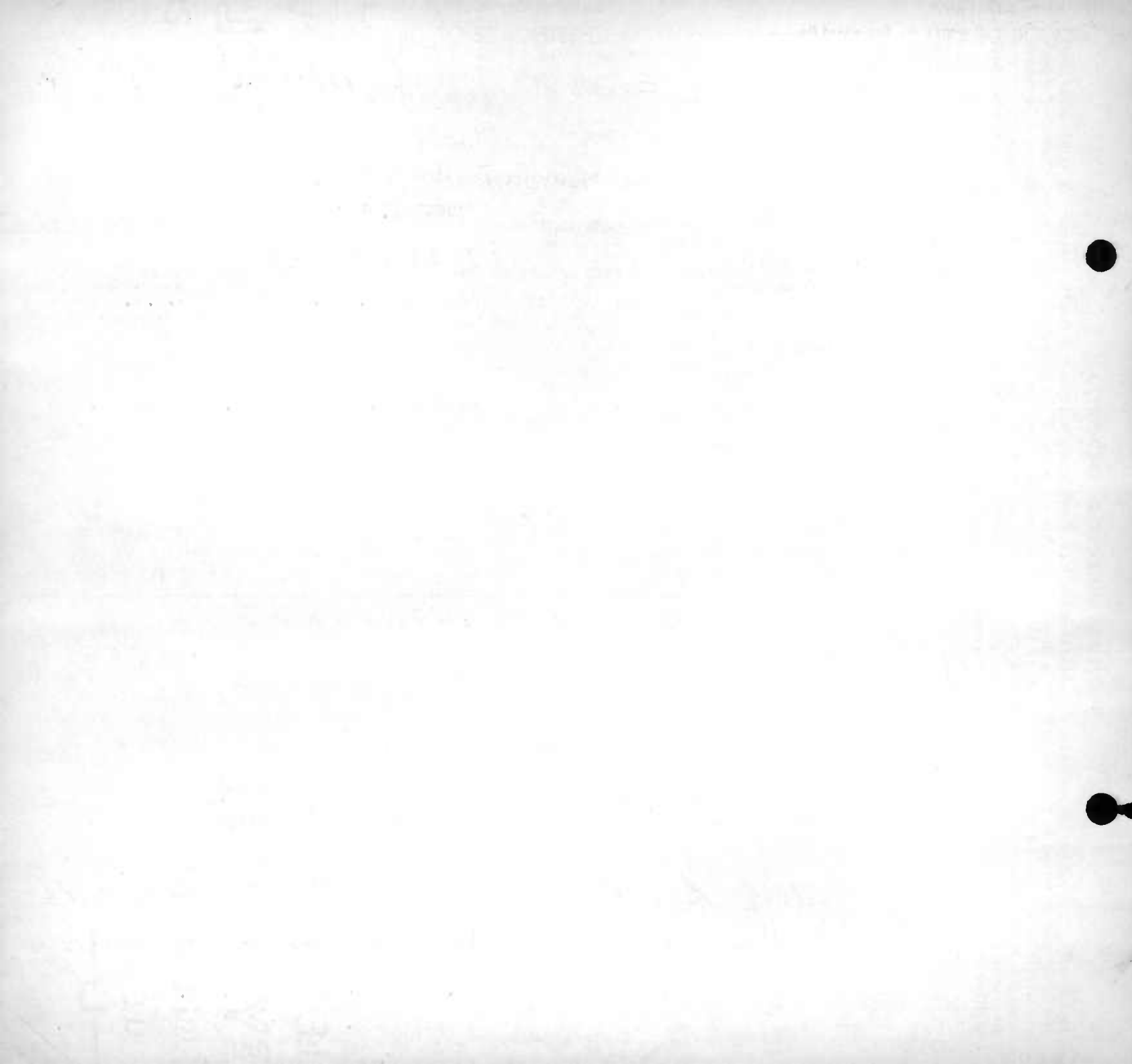
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | Registered No. <u>66 12682</u> | |
|--|-------------------------|---|---|---|--|
| BIRTH NO. <u>66 12682</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) <u>Robert C. Brown</u> | | | Dec 13, 1966 10:40 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>90 Bolton Hill Nursing Home</u> | | | A. STATE <u>Maryland</u> B. COUNTY | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | |
| | | | D. STREET ADDRESS (If rural, give location) <u>5210 Denmore Ave</u> | | |
| 5. SEX <u>Male</u> | 6. RACE <u>Negro</u> | 7. MARRIED, NEVER MARRIED <u>WIDOWED, DIVORCED (specify)</u> <u>Married</u> | B. DATE OF BIRTH <u>Oct 17, 1881</u> | 9. AGE (In years last birthday) <u>85</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Arundel Corp</u> | | 11. BIRTHPLACE (State or foreign country) <u>Stony Point Virginia</u> | |
| 13. FATHER'S NAME <u>Thomas Brown</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | | |
| 14. MOTHER'S MAIDEN NAME <u>Emily Walker</u> | | | 17. INFORMANT ADDRESS <u>Mrs. Irene B. Brown 5210 Denmore Ave</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>213-05-6728</u> | | | |
| 18. <u>422.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerotic</u> DUE TO <u>Cardiovascular Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>20 years</u> | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Dehydration</u> INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u> | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>June 24</u> 19 <u>66</u> to <u>December 13</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>December 12</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Stanley Z. Felsenberg</u> | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>12/15/66</u> |
| 23C. PHYSICIAN'S NAME (Type) <u>Stanley Z. Felsenberg</u> | | | 23D. ADDRESS <u>1129 E. Baltimore St. Balto. 2, Md.</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>Dec 16, 66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Memorial Park</u> | |
| | | | | 24D. LOCATION (City, town, or county) (State) <u>Arbutus Balto Co Md</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 19 1966</u> | | 25B. NAME OF REGISTRAR <u>R. E. Felsenberg</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>Herbert E. Nutter 3035 W. North Ave</u> | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|--|--|---|
| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12683 | |
| BIRTH NO. 66 12683 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) RIKE, MARTHA E. | | 12/12/66 2⁵⁰ P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL OF MARYLAND | | A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2860 W. Lanvale St | |
| 5. SEX FEMALE | 6. RACE NEGRO | 7. MARRIED/ NEVER MARRIED Married | 8. DATE OF BIRTH 9-23-03 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Keeper | | 10B. KIND OF BUSINESS OR INDUSTRY Catholic Rectory | 9. AGE (In years last birthday) 63 |
| 11. BIRTHPLACE (State or foreign country) Matthew Co. Va. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Anthony Jones | | 14. MOTHER'S MAIDEN NAME Mary F. Patterson | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 215-16-5882 | |
| 17. INFORMANT Charles M. Rice | | ADDRESS 2860 W. Lanvale St. | |
| 18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Uremia | | CAUSE OF DEATH (A) Uremia DUE TO (B) Kimmelstiel-Wilson Disease and Chronic Pyelonephritis DUE TO (C) | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | INTERVAL BETWEEN ONSET AND DEATH | |
| II | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 1) Hypertensive Arteriosclerosis, Cardiovascular Disease with Congestive Failure 2) Diabetes mellitus | | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) YES A | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec. 9 19 66 to Dec. 12 19 66 , that (I) (we) last saw the deceased alive on Dec. 12 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Young Kil Kim | | | 23B. DATE SIGNED 12/12/66 |
| 23C. PHYSICIAN'S NAME (Type) YOUNG KIL KIM M.D. | | 23D. ADDRESS LUTHERAN HOSPITAL OF MARYLAND | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 12/17/66 | 24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Pk. | 24D. LOCATION (City, town, or county) (State) Baltimore Co. Md. |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 19 1966 | | 25B. NAME OF REGISTRAR Herbert E. Nutter | |
| 25C. FUNERAL DIRECTOR Herbert E. Nutter | | ADDRESS 3035 W. North Ave. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | | | | | | | Registered No. <u>66 12684</u> |
|--|---------------------|--|--|--|--|--|--|---|--|----------------------------------|
| BIRTH NO. <u>66 12684</u> | | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>WASHINGTON JAMES</u> | | | | | 2. DATE AND HOUR OF DEATH <u>12-15-66 6 AM.</u> | | | | | M. |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>University of Md. Hospital</u> <u>38</u> | | | | | A. STATE <u>MARYLAND</u> | | | | | |
| (If not in hospital or institution, give street address or location) | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> | | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) <u>2227-PENROSE-AVE.</u> | | | | | |
| 5. SEX <u>M</u> | 6. RACE <u>N</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u> | | 8. DATE OF BIRTH <u>3-8-1890</u> | 9. AGE (In years last birthday) <u>76</u> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber Helper</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Essex Co Va.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 13. FATHER'S NAME <u>JAMES H WASHINGTON</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>?</u> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unknown</u> | | | | | 16. SOCIAL SECURITY NO. <u>212-09-7794</u> | | 17. INFORMANT <u>Mrs Ophelia Hill</u> | | | |
| | | | | | ADDRESS <u>237 MACON ST BROOKLYN N.Y.</u> | | | | | |
| 18. I <u>177 X I</u> | | | | | CAUSE OF DEATH | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | (A) <u>CARDIO RESPIRATORY FAILURE</u> | | | | | <u>IMMEDIATE</u> |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (B) <u>URAEIA</u> | | | | | |
| | | | | | (C) <u>CA PROSTATE</u> | | | | | |
| II | | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>CANCER CAE4EXIA</u> | | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| <u>0</u> | | <u>✓</u> | | | <u>✓</u> | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| <input type="checkbox"/> | | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | | |
| | | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12-13-66</u> 19 to <u>12-15-66</u> 19, that (I) (we) lost saw the deceased alive on <u>12-14-66</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE <u>A. S. GURUSHI</u> | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED <u>12/15/66</u> | | |
| 23C. PHYSICIAN'S NAME (Type) <u>A. S. GURUSHI</u> | | | | | 23D. ADDRESS <u>University Hospital</u> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>12/19/66</u> | | 24C. NAME of CEMETERY or CREMATORY <u>MT AUBURN Cem.</u> | | 24D. LOCATION (City, town, or county) (State) <u>CITY OF BALTIMORE Md</u> | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 19 1966</u> | | 25B. NAME OF REGISTRAR <u>R. E. JACOBI</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>HERBERT E NUTTER 3035 W. NORTH AVE</u> | | | | | | |

1875
E. X. CO. 1875
The Spirit of the Age
to the Editor of the
The Spirit of the Age

1875
The Spirit of the Age
The Spirit of the Age

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|--|--|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12685 | |
| BIRTH NO. 66 12685 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH DECEMBER 17, 1966 2:10A.M. | |
| 1. NAME OF DECEASED (Type or Print) THEODORACOS, PETER JAMES | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Balto. Co. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND ST. AGNES HOSPITAL FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) WILKENS & CATON AVES. BALTO., MD. 21229 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1928 ALTAVUE ROAD | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED MARRIED | 8. DATE OF BIRTH 6-16-22 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RESTAURANT PROPRIETOR | | 10B. KIND OF BUSINESS OR INDUSTRY RESTAURANT | 9. AGE (In years lost birthday) 44 |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JAMES THEODORACOS | | 14. MOTHER'S MAIDEN NAME STELLA NICHODULIS | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW2 | | 16. SOCIAL SECURITY NO. 218-12-2739 | |
| 17. INFORMANT WILKENS & CATON AVES. ST. AGNES HOSPITAL-BALTO., MD. 21229 | | 18. CAUSE OF DEATH Heart Failure (A) DUE TO Anemia severe (B) DUE TO Carcinoma, Colon (C) Metastases, Liver | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 153.81 | | INTERVAL BETWEEN ONSET AND DEATH 3+ mos | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION 12/8/66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Intestinal Obstruction | |
| 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 11-30 1966 to 12-17 1966 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12-17 1966 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Frank M. Detorie | | 23B. DATE SIGNED 12/17/66 | |
| 23C. PHYSICIAN'S NAME (Type) FRANK M. DETORIE, | | 23D. ADDRESS WILKENS & CATON AVES. ST. AGNES HOSPITAL BALTO., MD. 21229 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 12/20/1966 | 24C. NAME OF CEMETERY OR CREMATORY Orthodox Cemetery | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 19 1966 | 25B. NAME OF REGISTRAR Q. J. E. Faldut | 25C. FUNERAL DIRECTOR Eugenia K. Seitz 5209 York Rd. Balto. Md. 2 1212 | |

DECEMBER 17, 1954
JAMES EARL RAY
MEMPHIS, TENNESSEE
FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE

TO : DIRECTOR, FBI
FROM : SAC, MEMPHIS
SUBJECT: JAMES EARL RAY
RE: MEMPHIS TELETYPE TO BUREAU, 12/17/54

RE: RAY, JAMES EARL
ARRESTED 5/26/54
AT MEMPHIS, TENNESSEE
CHARGE: VIOLATION OF
FUGITIVE STATUS

12/18/54
JAMES EARL RAY
FUGITIVE STATUS
YES

12/17/54
JAMES EARL RAY
FUGITIVE STATUS
YES

12/17/54
JAMES EARL RAY
FUGITIVE STATUS
YES

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

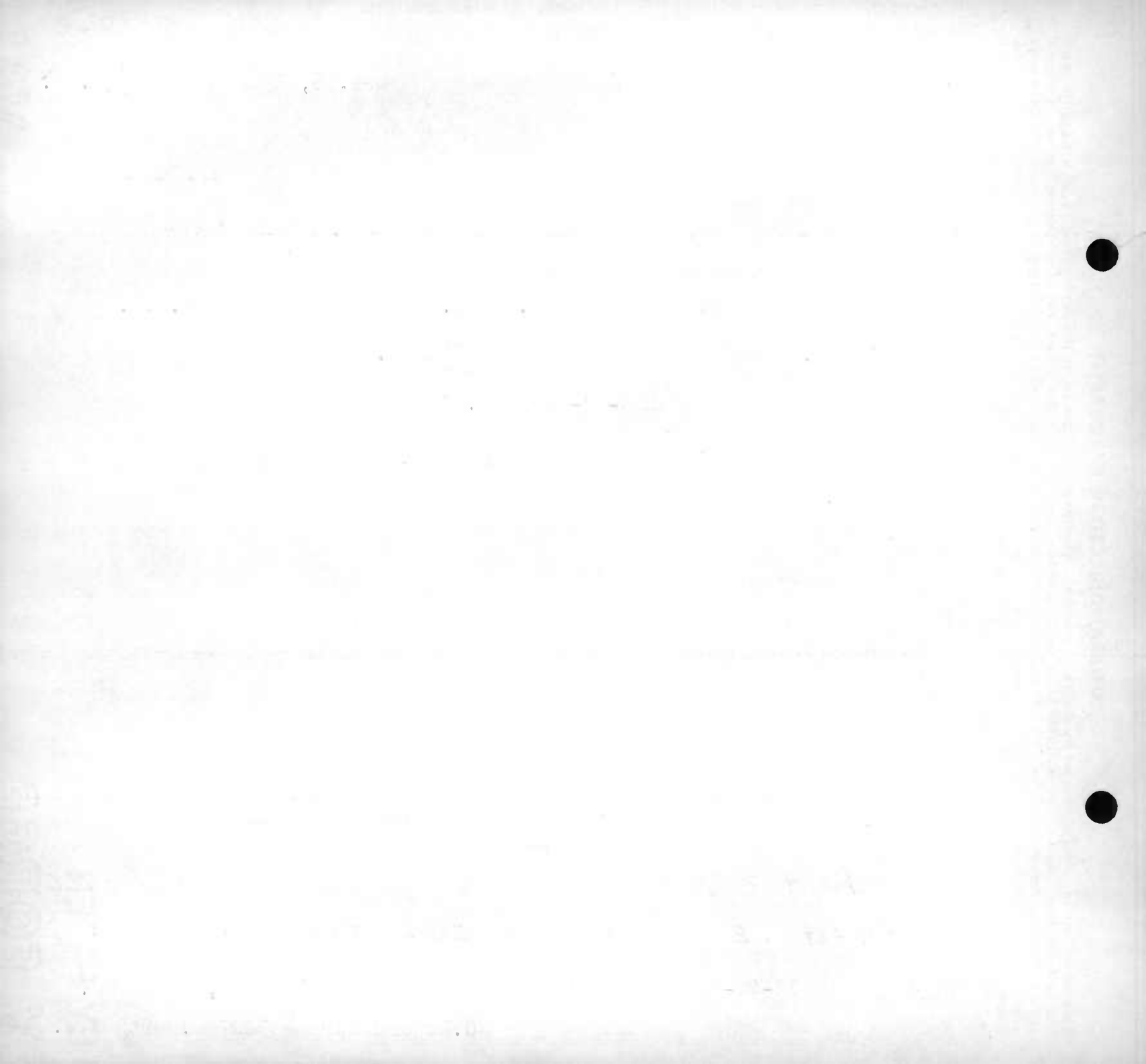
| | | | | | |
|--|-------------------------|--|-----------------------------------|--|---|
| BIRTH NO. 66 12686 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12686 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) KEECH, GERTRUDE E | | 2. DATE AND HOUR OF DEATH DECEMBER 14, 1966 7:55 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL CATON AND WILKENS AVENUE BALTIMORE MD. 21229 | | A. STATE MARYLAND | | B. COUNTY BALTIMORE | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | 33-00 | |
| | | D. STREET ADDRESS (If rural, give location) BLOOMSBURY RETREAT, BLOOMSBURY AVE. | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 8-4-76 | 9. AGE (In years last birthday) 90 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | | 10B. KIND OF BUSINESS OR INDUSTRY NONE | | 11. BIRTHPLACE (State or foreign country) NEW YORK | |
| 12. CITIZEN OF WHAT COUNTRY? U S A | | 13. FATHER'S NAME UNKNOWN | | 14. MOTHER'S MAIDEN NAME GERTRUDE (MAIDEN NAME UNKNOWN) | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. * | | 17. INFORMANT CATON & WILKENS AVE #29 HOSPITAL SLIP/ST. AGNES HOSPITAL | |
| 18. 722.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Acute pulmonary edema DUE TO (B) ASCVD DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH 10 hrs years | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pagets disease of vulva | | | | 5 yrs | |
| 19A. DATE OF OPERATION 12/9/66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Biopsy of vulva | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that XX (this hospital) attended the deceased from DECEMBER 9, 1966 to DECEMBER 14, 1966 , that X (we) lost saw the deceased alive on DECEMBER 14, 1966 and that in XX (our) opinion death occurred on the date and hour and from the causes stated above. X (We) (did) (XXX) view the body after death. | | | | | |
| 23A. SIGNATURE Paul F. Kaminski | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/14/66 | |
| 23C. PHYSICIAN'S NAME (Type) PAUL F. KAMINSKI | | M.D. 23D. ADDRESS ST. AGNES HOSPITAL/CATON & WILKENS AVES. | | BALTIMORE, MD. 21229 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-17-1966 | | 24C. NAME of CEMETERY or CREMATORY Hillcrest Park | |
| 24D. LOCATION Springfield, Mass | | 24E. CITY, town, or county Springfield, Mass | | 24F. STATE Mass | |
| 25A. DATE RECEIVED BY HEALTH DEPT. DEC 15 1966 | | 25B. NAME OF REGISTRAR John E. Johnson | | 25C. FUNERAL DIRECTOR Higginbotham FEN. H. E. Nicoll City | |

23:5

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12687 | |
|--|------------------|--|---|--|--|
| BIRTH NO. 66 12687 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) George Davis Shedd | | 2. DATE AND HOUR OF DEATH Dec. 16, 1966 10. P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5411 Sagra Road 00 | | A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 5411 Sagra Road | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widower | 8. DATE OF BIRTH 12/25/1892 | 9. AGE (In years last birthday) 73 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper | | 10B. KIND OF BUSINESS OR INDUSTRY Standard Oil Co. | | 11. BIRTHPLACE (State or foreign country) Md. | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME William H. Shedd | | | 14. MOTHER'S MAIDEN NAME Ella V. Toner | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 215-03-2693 | | 17. INFORMANT ADDRESS W. Gilbert Shedd 5411 Sagra Road | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CORONARY OCCLUSION | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION D | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from OCT 1 19 52 to DEC 16 19 66, that (I) last saw the deceased alive on DEC 12 19 66 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Robert E. May M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED 12/17/66 | |
| 23C. PHYSICIAN'S NAME (Type) ROBERT E. MAY | | 23D. ADDRESS 5662 THE ALAMEDA | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-20-1966 | | 24C. NAME OF CEMETERY or CREMATORY Loudon Park | |
| 24D. LOCATION Baltimore, Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 18 1966 | | 25B. NAME OF REGISTRAR Robert E. May | | 25C. FUNERAL DIRECTOR ADDRESS G. Howard Strong 3207 W. North Ave. | |



66 12688

BALTIMORE CITY HEALTH DEPARTMENT

66 12688

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

EDWARD RODGERS

2. DATE AND HOUR PRONOUNCED DEAD

12-11-66

9:45 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
ADDRESS OR LOCATION)

44 UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3530 Greenmount Avenue 21218

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)

64

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Employee

10B. KIND OF BUSINESS OR INDUSTRY

Race tracks

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

(?) Rodgers (dece'd)

14. MOTHER'S MAIDEN NAME

Lily Junkins (dec'd)

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown; If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Anna McCleary Rodgers

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Gunshot wound of head
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

HOME

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

3530 Greenmount Ave.

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

12 10 66 10:50 PM

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Shot self in head

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

WERNER U. SPITZ, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-12-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/15/66

23C. NAME OF CEMETERY or CREMATORY

Greenmount Cem

23D. LOCATION

Balto.

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

DEC 19 1966

24B. NAME OF REGISTRAR

Robert E. Farley

24C. FUNERAL DIRECTOR

Mitchell-Wiedefeld Home, Inc.
6500 York Rd. 21212

ADDRESS

Letter from M. F. Office
4-20-67 M.H.

returned to M. F. Office
2-10-215 - M. F. returned it
without the information on

VALLEY PARK

VALLEY FORCE

VALLEY CONTENT

111

111

111

111

111

111

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|--|------------------|--|---|---------------------------------------|--|--|--|--|--|--|
| 66 12689 | | | | | CERTIFICATE OF DEATH | | Registered No. 66 12689 | | | |
| BIRTH NO. 66 12689 | | | | | M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) Sue Waters Worley | | | | | 2. DATE AND HOUR OF DEATH Dec. 12, 1966 | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Long Green Nursing Home | | | | | A. STATE Maryland B. COUNTY | | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 12-02 | | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) Homewood Apts. | | | | | |
| 5. SEX female | 6. RACE white | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) single | 8. DATE OF BIRTH 9/31/1886 | 9. AGE (In years last birthday) 80 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME William N. Worley | | | | | 14. MOTHER'S MAIDEN NAME Magrauder | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | | 16. SOCIAL SECURITY NO. 215-03-8081 | | 17. INFORMANT ADDRESS Mercantile Safe Deposit & Trust Co. | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 331X1 | | | CAUSE OF DEATH 13 South St. #2 | | | INTERVAL BETWEEN ONSET AND DEATH 2-3 mos. | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) Due to Cerebro-vascular disease (Hemorrhage) (B) Due to Hypertension (C) Due to Arterio-sclerosis | | | Gradual | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II | | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Net While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Oct 1930 to Dec 12 1966, that (I) (we) last saw the deceased alive on Dec 11 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE Dr. William Woody | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED 12-14-66 | | |
| 23C. PHYSICIAN'S NAME (Type) Dr. William Woody | | | | | 23D. ADDRESS 1403 Park Ave. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 24B. DATE 12/15/66 | | 24C. NAME of CEMETERY or CREMATORY Loudon Park | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 19 1966 | | | 25B. NAME OF REGISTRAR R. E. Taylor | | | 25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home | | | ADDRESS 6500 York Rd Balto. 12, Md. | |

1.

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1/11

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12690 | |
|---|-------------------------|---|---|---|--|
| BIRTH NO. 66 12690 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) MASER, Clifford Edward | | | 2. DATE AND HOUR OF DEATH December 13, 1966 12 Noon M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 27 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218 | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL, and give township) Baltimore D. STREET ADDRESS (If rural, give location) 401 Highland Avenue | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced | 8. DATE OF BIRTH 3-5-08 | 9. AGE (In years last birthday) 58 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic | | 10B. KIND OF BUSINESS OR INDUSTRY Unknown | 11. BIRTHPLACE (State or foreign country) Wisconsin | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. |
| 13. FATHER'S NAME Henry Maser | | | 14. MOTHER'S MAIDEN NAME Ella Gustafson | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 3-30-44 to 3-8-46 | | | 16. SOCIAL SECURITY NO. 491-22-7131 | | 17. INFORMANT ADDRESS Records V. A. Hospital, Baltimore, Md. 21218 |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 527.14002.2 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Respiratory Failure | | | INTERVAL BETWEEN ONSET AND DEATH 12 hours | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from December 2, 1966 to December 13, 1966 , that (X) (we) last saw the deceased alive on December 13, 1966 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death. | | | | | |
| 23A. SIGNATURE Joel Habener M.D. | | | | 23B. DATE SIGNED 12/14/66 | |
| 23C. PHYSICIAN'S NAME (Type) JOEL HABENER | | | | 23D. ADDRESS M.D. V. A. Hospital, Baltimore, Md. 21218 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/16/66 | | 24C. NAME OF CEMETERY OR CREMATORY Baltimore National Cem. Baltimore Co., Md. | |
| 24D. LOCATION (City, town, or county) (State) Baltimore Co., Md. | | 25A. DATE REC'D BY HEALTH DEPT. DEC 19 1966 | | | |
| 25B. NAME OF REGISTRAR Robert E. Feltner | | 25C. FUNERAL DIRECTOR ADDRESS William E. Johnson 8521 Loch Raven Blvd. | | | |

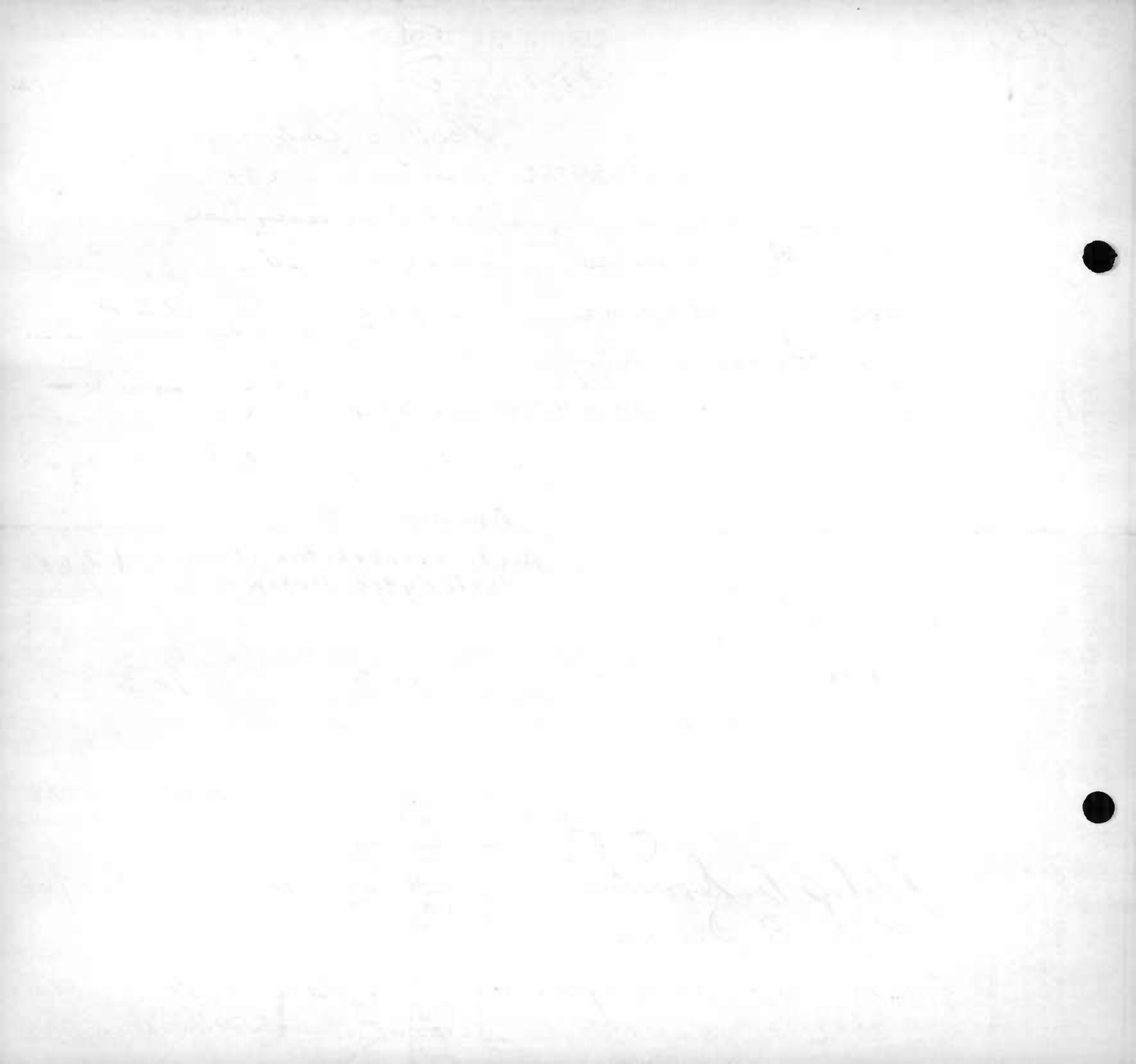
1/24/67 ac. Resp. Failure
chronic lat. pulm. emphysema
Pulm TB - inactive -
see letter from V.A.H.-L.R.-in Doc't file
Bur. of TB - American Bldg. &c

for specimen

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

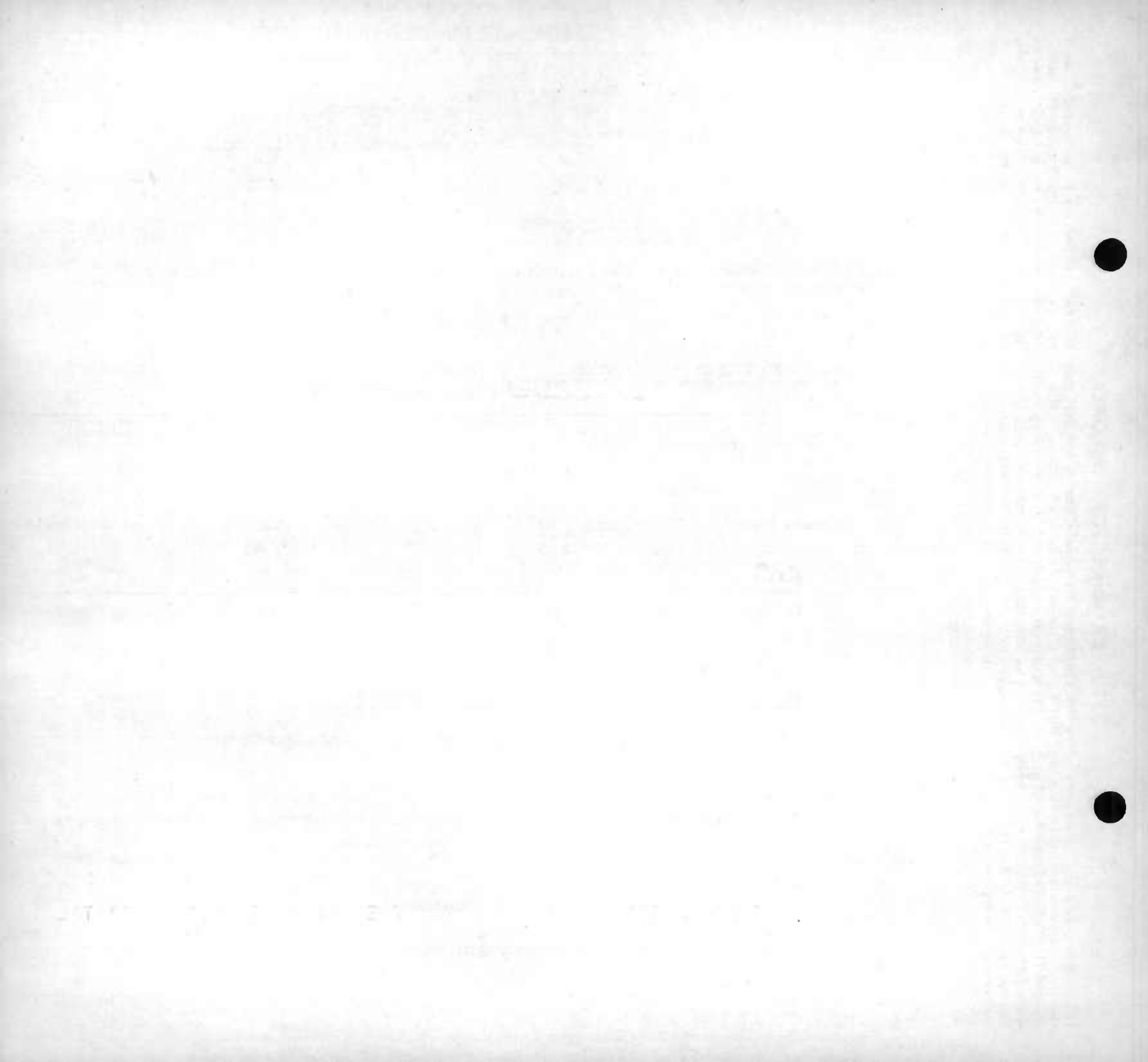
| | | | |
|---|---|---|--|
| 66 12691 BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <i>Francis Stirling</i> | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH Registered No. <i>66 12691</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>37 Mercy Hospital</i> | | 2. DATE AND HOUR OF DEATH <i>12/14/66 12:08 PM</i> 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore Co.</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 21234 53-00</i> D. STREET ADDRESS (If rural, give location) <i>8109 Glen Cary Road</i> | |
| 5. SEX <i>m</i> 6. RACE <i>w</i> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i> | 8. DATE OF BIRTH <i>Jan. 22 1901</i> 9. AGE (In years lost birthday) <i>65</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Broker</i> 10B. KIND OF BUSINESS OR INDUSTRY <i>Real Estate</i> 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i> | |
| 13. FATHER'S NAME <i>George Howard Stirling</i> | | 14. MOTHER'S MAIDEN NAME <i>Mary Siller</i> 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> 16. SOCIAL SECURITY NO. <i>213 01 9790</i> 17. INFORMANT <i>Edwin Nelson Brothers</i> | |
| 18. <i>204.11</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH (A) DUE TO <i>Acute Myocardial infarction</i> (B) DUE TO <i>Anemia 20 to</i> (C) <i>Acute exacerbation chronic Myelocytic leukemia</i> INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>6 2 mo</i> | |
| MEDICAL CERTIFICATION 19A. DATE OF OPERATION <i>2 NONE</i> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i> 20A. AUTOPSY? (Yes or No) <i>YES</i> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>YES</i> | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner) <i>NONE</i> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>—</i> 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>—</i> 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>—</i> 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? <i>—</i> | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>11/12/66</i> 19 <i>66</i> to <i>12/14</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>12/14</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <i>Philip B. Droskin</i> 23C. PHYSICIAN'S NAME (Type) <i>Philip B. Droskin</i> | | 23B. DATE SIGNED <i>12/14/66</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> 23D. ADDRESS <i>—</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> 24B. DATE <i>12/17/66</i> 24C. NAME OF CEMETERY or CREMATORY <i>Dulaney Valley Memorial</i> | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore Co. Md.</i> 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 19 1966</i> 25B. NAME OF REGISTRAR <i>Robert E. Johnson</i> 25C. FUNERAL DIRECTOR <i>William Johnson</i> | |
| ADDRESS <i>8521 Loch Raven Blvd.</i> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

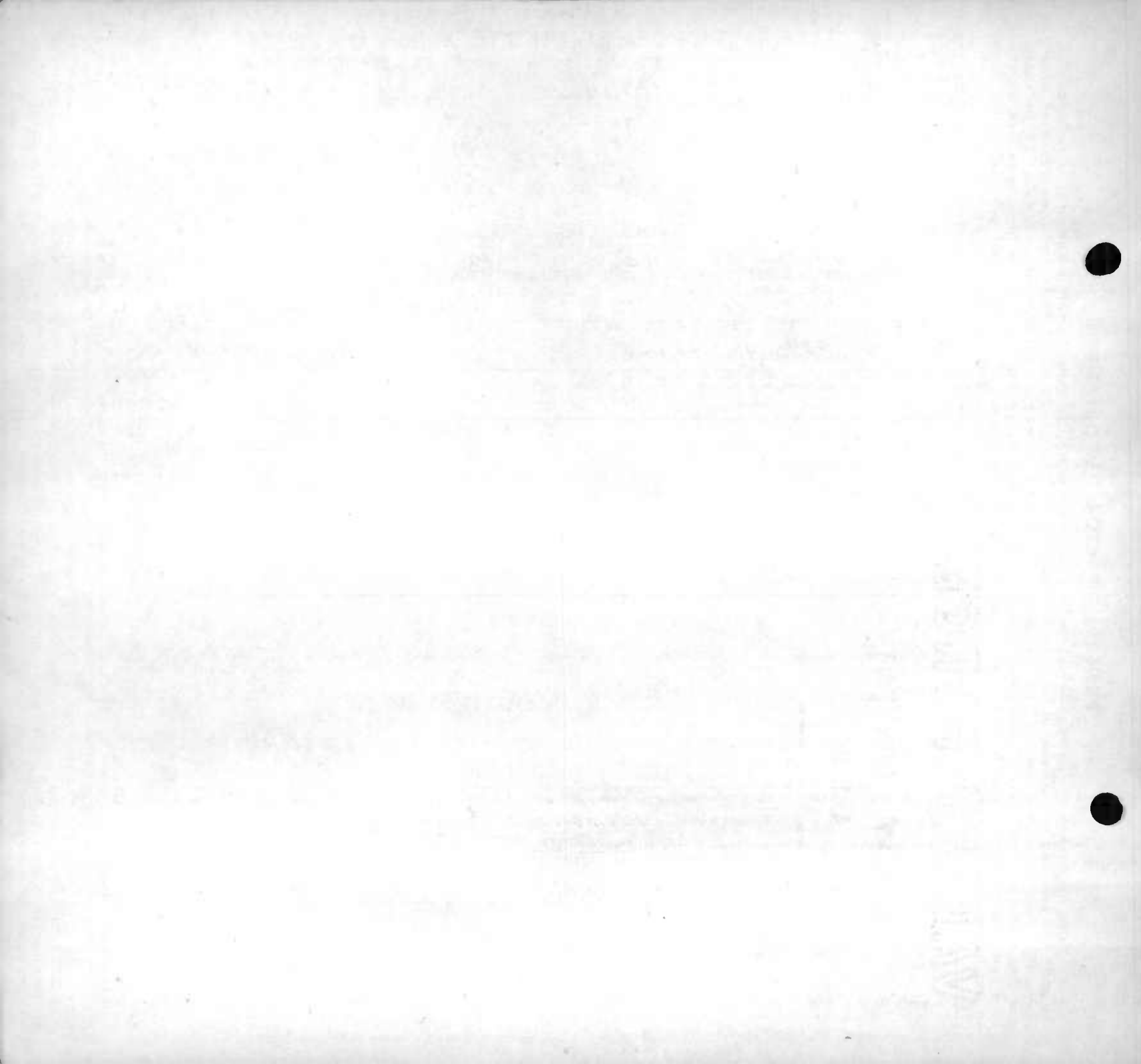
| | | | | | |
|--|------------------------------|--|---|---|--|
| BIRTH NO. 66 12692 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 12692 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <i>Baby girl Baker</i> | | | 2. DATE AND HOUR OF DEATH <i>12/13/66 3:15 P.M.</i> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Union Memorial Hosp.</i> | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 11-01</i> D. STREET ADDRESS (If rural, give location) <i>807 St Paul St</i> | | |
| 5. SEX <i>F</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>no</i> | 8. DATE OF BIRTH <i>12/13/66</i> | 9. AGE (In years last birthday) <i>80 min</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. <i>80</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>newborn</i> | 11. BIRTHPLACE (State or foreign country) <i>Baltimore</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>us</i> |
| 13. FATHER'S NAME <i>Alexander Baker</i> | | | 14. MOTHER'S MAIDEN NAME <i>Brenda Baldwin</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i> | | 16. SOCIAL SECURITY NO. 02632594 | 17. INFORMANT <i>Mrs Brenda Baker</i> | | ADDRESS <i>same</i> |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>773.51 Prematurity</i> | | | CAUSE OF DEATH (A) DUE TO <i>80 min</i> | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Cardioresp. arrest</i> | | | (B) DUE TO <i>80 min</i> | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | (C) <i>3w</i> | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>12/13</i> 19 <i>66</i> to <i>12/13</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>12/13</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Geodon Bretz</i> | | | M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | 23B. DATE SIGNED <i>12/13/66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>DR. GEDEON BRETZ</i> | | | 23D. ADDRESS <i>Union Mem. Hosp.</i> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE <i>12-15-66</i> | 24C. NAME OF CEMETERY or CREMATORY <i>JOHNS HOPKINS MEDICAL SCHOOL</i> | | 24D. LOCATION (City, town or county) (State) <i>MORTUARY SERVICE - BCS</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 20 1966</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Talley</i> | | 25C. FUNERAL DIRECTOR <i>JOHNS HOPKINS MEDICAL SCHOOL</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12693 4 | |
|--|-------------------------|--|---|---|--|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 66 12693 M.E. CASE NO. 66-26852 | | 1. NAME OF DECEASED (Type or Print) <u>Baby Girl "B" Adams</u> | | 2. DATE AND HOUR OF DEATH <u>December 13 1966 405 P.M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Md Gen Hosp</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore #14 15-13</u> D. STREET ADDRESS (If rural, give location) <u>2712 Shirley Avenue</u> | | |
| 5. SEX <u>Female</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>NB</u> | 8. DATE OF BIRTH <u>12-13-66</u> | 9. AGE (In years last birthday) | If Under 1 Yr. Months: Days: Hours: Min. <u>11 42</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 13. FATHER'S NAME <u>Robert Wellington Adams Jr.</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u> | | |
| 14. MOTHER'S MAIDEN NAME <u>Donna Mae Kruelle</u> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u> | | |
| 16. SOCIAL SECURITY NO. <u>—</u> | | 17. INFORMANT <u>Mother</u> | | ADDRESS <u>same</u> | |
| 18. <u>762.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | CAUSE OF DEATH (A) <u>Respiratory distress</u> DUE TO (B) <u>asphyxia</u> DUE TO (C) <u>—</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>4 Hrs.</u> |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? <u>Yes</u> or No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12 - 13</u> 19 <u>66</u> to <u>December 13</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>December 13</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Dr. Honarvar M.D.</u> | | | | 23B. DATE SIGNED <u>Dec 13 1966</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Dr. Ira Honarvar</u> | | 23D. ADDRESS <u>Md. General Hospital</u> | | | |
| 24A. BURIAL CREMATION REMOVAL (Specify) <u>12-19-66</u> | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| 24D. LOCATION (City, town, or county) (State) | | 24E. DATE REC'D BY HEALTH DEPT. <u>DEC 20 1966</u> | | | |
| 24F. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 24G. FUNERAL DIRECTOR <u>JOHNS HOPKINS MEDICAL MORTUARY SERVICE - DCID</u> | | | |



1
L-53566 12694
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 12694

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

RUTH GAITHER LANDON

2. DATE AND HOUR PRONOUNCED DEAD

December 4, 1966 1:45 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

ALL PLACES OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
HOSPITAL OR ADDRESS OR LOCATION)
INSTITUTION 3-3-67

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

410 E. Lanvale Street

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years
lost birthday)

47

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

581.0 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Acute Pancreatitis

(A) Cirrhosis of Liver
DUE TOINTERVAL BETWEEN
ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Cirrhosis of Liver
DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenecker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

12-15-66

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

DEC 20 1966

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

ADDRESS

MORTUARY SERVICE - DCHD

VALLEY FIER

VALLEY FORCE

2440 BENTLEY

R-150

66 12695

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 12695

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIE

RUFFIN

2. DATE AND HOUR PRONOUNCED DEAD

December 5, 1966

7:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

430 N. Fremont Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

430 N. Fremont Avenue

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)
65If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Congestive Heart Failure
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Carcinoma of Lungs (History)
DUE TO

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)
(Month) (Day) (Year) (Hour)
m.

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/5/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

12-15-66

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

DEC 20 1966

Robert E. Farkas

MORTUARY SERVICE - BCHD

WALTER BOWEN
JANUARY 1961

1
G-656

66 12696

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12696

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

PAULINE

GARNER

2. DATE AND HOUR PRONOUNCED DEAD

December 4, 1966

5:20 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 1402 E. Fairmont Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1402 E. Fairmont Avenue

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)
62If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenecker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/5/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

12-15-66

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

DEC 20 1966

Robert E. Taylor, M.D.

MORTUARY SERVICE - BCHD

WILSON & SONS

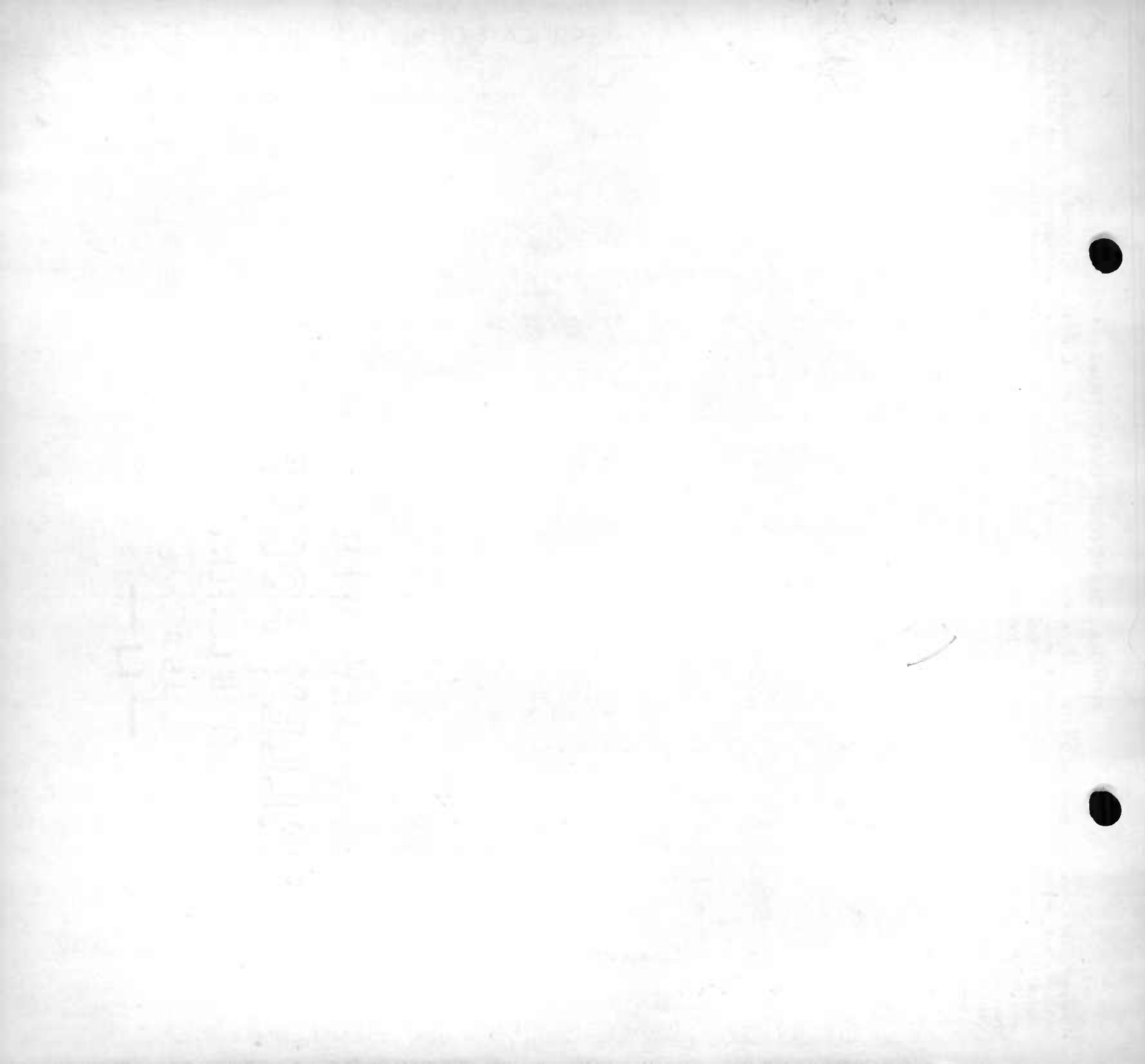
WILSON & SONS

WILSON & SONS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|--------------------|---|---|
| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12697 9 | |
| BIRTH NO. 66 12697 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH 11/9/66 7 P.M. | |
| 1. NAME OF DECEASED (Type or Print) Baby Boy Rivers | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE md. B. COUNTY X | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto. | |
| FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hosp. | | D. STREET ADDRESS (If rural, give location) 759 W. Fayette St. | |
| 5. SEX m | 6. RACE N C | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) - | 8. DATE OF BIRTH 11/9/66 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY - | 9. AGE (In years last birthday) 5 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 11. BIRTHPLACE (State or foreign country) md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Frank Rivers | | 14. MOTHER'S MAIDEN NAME Corine Richers | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) - | | 16. SOCIAL SECURITY NO. - | |
| 17. INFORMANT - | | ADDRESS - | |
| 18. 762.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Bilateral Pneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Bilateral Atelectasis | | CAUSE OF DEATH (A) DUE TO Bilateral Pneumonia (B) DUE TO Bilateral Atelectasis (C) - | |
| INTERVAL BETWEEN ONSET AND DEATH - | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED - | |
| 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? - | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) - | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) - | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) - | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? - | |
| 22. I certify that (1) (this hospital) attended the deceased from 11/9/66 to 11/9/66 , that (1) (we) saw the deceased alive on 11/9/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did not) view the body after death. | | | |
| 23A. SIGNATURE A. Rosenstein | | 23B. DATE SIGNED 11/9/66 | |
| 23C. PHYSICIAN'S NAME (Type) A. Rosenstein | | 23D. ADDRESS - | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) 12-13-66 | | 24B. DATE 12-13-66 | |
| 24C. NAME OF CEMETERY or CREMATORY - | | 24D. LOCATION (City, town, or county) (State) - | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 20 1966 | | 25B. NAME OF REGISTRAR Robert E. Taylor | |
| 25C. FUNERAL DIRECTOR - | | ADDRESS - | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|--|---------------------|---|-------------------------------------|--|---|
| BIRTH NO. 66 12698 | | CERTIFICATE OF DEATH | | 66 12698 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Byrd, Maggie Belle | | 2. DATE AND HOUR OF DEATH 12/7/66 12:23 P.M. | |
| 3. PLACE OF DEATH (In Baltimore, Maryland) | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Howard Co | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION University Hospital 38 Balto, Md. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Highland, Maryland 63-00 | | D. STREET ADDRESS (If rural, give location) | |
| 5. SEX F | 6. RACE C | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Separated | 8. DATE OF BIRTH 11/18/27 | 9. AGE (In years last birthday) 38 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown | | 10B. KIND OF BUSINESS OR INDUSTRY - | | 11. BIRTHPLACE (State or foreign country) Unknown | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME John Mackins | | 14. MOTHER'S MAIDEN NAME Susie King | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. - | | 17. INFORMANT Hospital Chart | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Renal failure and embolus | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) Chronic alcoholism | | INTERVAL BETWEEN ONSET AND DEATH 4 weeks. months. years. | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Gastric ulcer & Bleeding | | 8 months. | |
| 19A. DATE OF OPERATION 12/6/66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Bleeding Gastric ulcer | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 11/19/66 to 12/7/66 , that (I) (we) lost saw the deceased alive on 12/7/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Peter S. Mackinway | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/7/66 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 12-13-66 | | 24C. NAME OF CEMETERY or CREMATORY | |
| 24D. LOCATION (City, town, or county) | | 24E. ADDRESS | | 24F. MORTUARY SERVICE - BOLD | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR | |

12/1/66 12/1/66 12/1/66

Highland, Maryland
Baltimore

12/1/66 12/1/66 12/1/66

Separated

12/1/66 12/1/66 12/1/66

Highland, Maryland
Baltimore

John Throckmorton

Chronic osteoarthritis
from
trauma
renal failure
and
hypertension

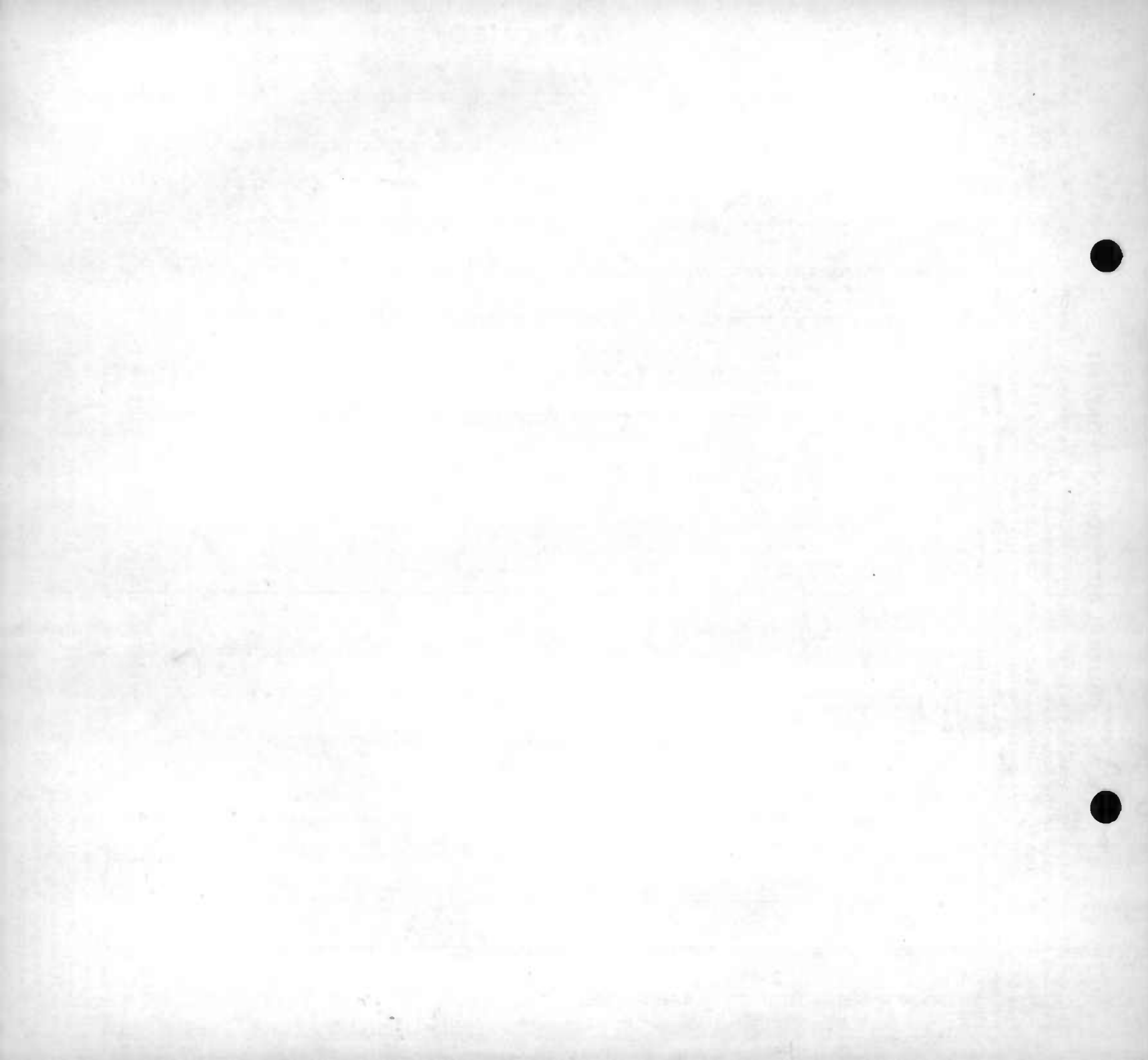
12/1/66 12/1/66 12/1/66

12/1/66 12/1/66 12/1/66

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12699 | |
|---|--|--|--|--|--|
| BIRTH NO. 66 12699 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | |
| 66-26602 | | | | Ronnie Lancaster | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | 2. DATE AND HOUR OF DEATH | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | Dec 18, 1966 11:05 A.M. | |
| 48 md. GEN. Hosp. | | Md. Baltimore | | | |
| 5. SEX | | 6. RACE | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| Male | | W | | 21211 | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | |
| N.B. | | Dec 13, 1966 | | 13-05 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| | | | | md | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| George Lockard | | Linda Lancaster | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | mother same | |
| 18. 773.5 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES | | (A) Respiratory Distress Syndrome | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) Immaturity | | | |
| | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec 13 1966 to Dec 18 1966, that (I) (we) last saw the deceased alive on Dec 18 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Maldonado, M.D. M.D. | | | | Dec 18, 1966 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| | | M.D. ANATOMY BOARD OF MARYLAND | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| | | 12-19-66 | | 24D. LOCATION (City, town, or county) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| DEC 20 1966 | | Robert E. Fisher, M.D. | | MORTUARY SERVICE - BCUH | |



L-2501

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--|---|--|--|---|
| BIRTH NO. 66 12700 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 12700 | |
| 1. NAME OF DECEASED (Type or Print) <i>Baby Girl Logan</i> | | | 2. DATE AND HOUR OF DEATH <i>Dec 6, 1966 1615 P.M.</i> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hosp</i> 38 (If not in hospital or institution, give street address or location) | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE _____ B. COUNTY _____ C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>25-33 Baltimore #30</i> D. STREET ADDRESS (If rural, give location) <i>2628 Pierpont St #30</i> | | |
| 5. SEX <i>7</i> | 6. RACE <i>N</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) _____ | 8. DATE OF BIRTH <i>12-9-66</i> | 9. AGE (In years last birthday) <i>0 2</i> | 10. Under 1 Yr. Months Days <i>0 2</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) <i>Md.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> |
| 13. FATHER'S NAME <i>George Logan</i> | | | 14. MOTHER'S MAIDEN NAME <i>Viola Jackson</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>262.01 Perinatal hypoxia</i> | | CAUSE OF DEATH (A) DUE TO <i>Perinatal hypoxia</i> (B) DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>RUL pneumonia</i> | | | | | |
| 19A. DATE OF OPERATION <i>2</i> | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) <i>YES</i> | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (A) (this hospital) attended the deceased from <i>12/4</i> 19 <i>66</i> to <i>12/6</i> 19 <i>66</i> , that (B) (last saw the deceased alive on <i>12/6</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (C) (I) (we) (did) (do not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Alfred Robertson</i> | | | 23B. DATE SIGNED <i>12/6/66</i> | | |
| 23C. PHYSICIAN'S NAME (Type) | | | 23D. ADDRESS | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE <i>12-13-66</i> | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR <i>Robert E. Farkner</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCH</i> | |

FUNERAL DIRECTOR: IMPORTANT

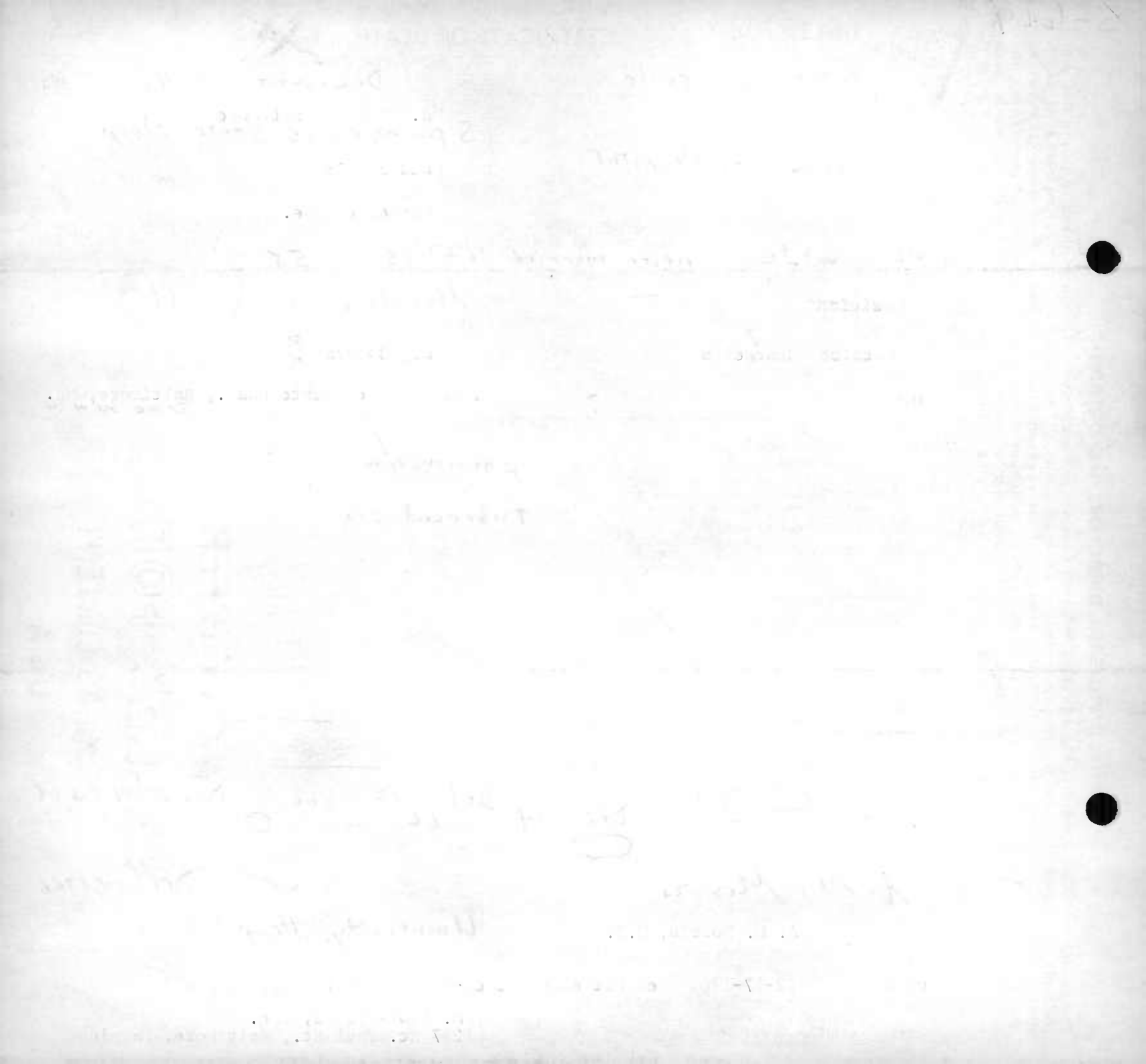
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. <u>66 12701</u> | |
|--|---------------------|--|--------------------------------------|--|---|--|---|
| BIRTH NO. <u>66 12701</u> | | | | | | | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Millard R. Smith</u> | | | | 2. DATE AND HOUR OF DEATH <u>Dec. 17, 1966</u> <u>3:45 A.M.</u> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>00 1601 S. Charles street</u> <u>Baltimore Md.</u> | | | | A. STATE <u>Md.</u> B. COUNTY | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore City</u> <u>23-02</u> | | | |
| | | | | D. STREET ADDRESS (If rural, give location) <u>1601 S. Charles Street</u> | | | |
| 5. SEX <u>M</u> | 6. RACE <u>C</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>M</u> | 8. DATE OF BIRTH <u>3-21-1890</u> | 9. AGE (In years (last birthday)) <u>76</u> | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trainman, Railroad</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>James B. Smith</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Molly Ritchie</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes</u> <u>World War I</u> | | 16. SOCIAL SECURITY NO. <u>705-12-3298</u> | | 17. INFORMANT <u>MRS. Mary E. Smith (wife)</u> | | ADDRESS <u>same</u> | |
| 18. <u>420.0</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerotic heart disease</u> | | | | CAUSE OF DEATH (A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO | | | |
| | | | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION <u>None</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-</u> | | 20A. AUTOPSY? (Yes or No) <u>no</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>no</u> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-</u> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>-</u> | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>-</u> | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? <u>-</u> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>August 3 - 1959</u> to <u>Dec. 17 - 1966</u> , that (I) (we) last saw the deceased alive on <u>Dec. 16 - 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>C. Chiu</u> | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>Dec. 17, 1966</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>G. C. CHIU</u> | | | | 23D. ADDRESS <u>1 E. Randall Street, Baltimore Md.</u> | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u> | | 24B. DATE <u>12/2/66</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Beeth</u> | | 24D. LOCATION (City, town, or county) (State) <u>Beeth</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 20 1966</u> | | 25B. NAME OF REGISTRAR <u>R. E. F. F.</u> | | 25C. FUNERAL DIRECTOR <u>W. F. F.</u> | | ADDRESS <u>130 E. Toa St</u> | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

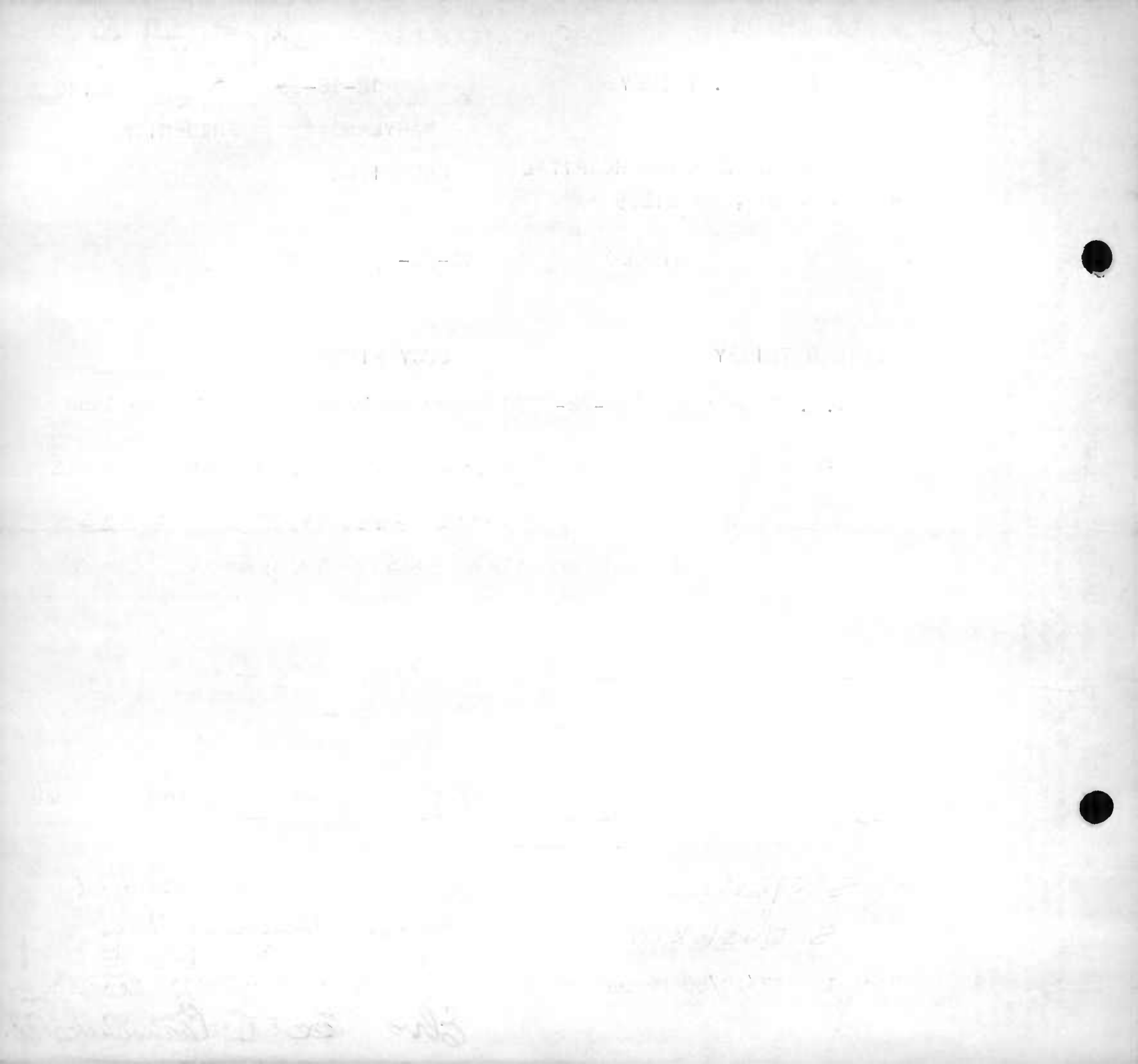
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 12702</u> | |
|---|-------------------------|---|------------------------------------|--|--|
| BIRTH NO. <u>66 12702</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Peter Scarpello</u> | | 2. DATE AND HOUR OF DEATH <u>December 14, 1966 3:30a.m.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>University Hospital</u> | | A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Catonsville 10-01</u> | | | |
| D. STREET ADDRESS (If rural, give location) <u>Frederick Ave. 1100 Blk. - PROCTOR ST</u> | | | | | |
| 5. SEX <u>male</u> | 6. RACE <u>white</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>never married</u> | 8. DATE OF BIRTH <u>1/27/08</u> | 9. AGE (In years last birthday) <u>58</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Musician</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | | | | |
| 13. FATHER'S NAME <u>Cotaiso Scarpello</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Sodora</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>?</u> | | 17. INFORMANT ADDRESS <u>Spring Grove State Hosp., Baltimore, Md. Same as H 4</u> | |
| 18. <u>002.11</u> | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) | | (A) <u>pneumonia</u> | | | |
| ANTECEDENT CAUSES | | (B) <u>tuberculosis</u> | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) _____ | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At _____ Not While At Work _____ | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>Dec. 12 1966</u> to <u>Dec. 14 1966</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>Dec. 14 1966</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> <u>(did)</u> (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>A. M. Morris</u> | | | | 23B. DATE SIGNED <u>Dec. 14, 1966</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>A. M. Morris, M.D.</u> | | | | 23D. ADDRESS <u>University Hospital</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12-17-1966</u> | | 24C. NAME of CEMETERY or CREMATORY <u>New Cathedral Cemetery</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 20 1966</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Farley</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>Wm. Cook-Brooks, Inc. 1217 St. Paul St., Baltimore, Maryland</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | | | | | | | | | | | | | |
|---|--|--------------|--|--|---|------------------------------------|--|---|--------------------------|---|--|------------------------------|--|--|--|--|
| BIRTH NO. 66 12703 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 66 12703 | | | | | | |
| 1. NAME OF DECEASED (Type or Print) PAUL E. TRIBBY | | | | | | | | | | 2. DATE AND HOUR OF DEATH 12-16-66 10:10 A.M. | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205 | | | | | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY FREDERICK Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) KNOXVILLE 60-00 D. STREET ADDRESS (If rural, give location) | | | | | | |
| 5. SEX M | | 6. RACE W | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE | | 8. DATE OF BIRTH 12-30-27 | | 9. AGE (In years last birthday) 38 | | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | | | |
| 13. FATHER'S NAME LUTHER TRIBBY | | | | | | | | | | 14. MOTHER'S MAIDEN NAME LUCY HIMES | | | 17. INFORMANT Peggy Taulton | | ADDRESS Knoxville Maryland | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes W.W.II Army | | | | | 16. SOCIAL SECURITY NO. 216-22-1779 | | | | | | | | | | | |
| 18. 457X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | CAUSE OF DEATH (A) DISSECTING ANEURYSM DUE TO (B) AORTIC ANEURYSM DUE TO (C) MARFAN'S SYNDROME | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 DAYS 3 YRS 38 YR | |
| MEDICAL CERTIFICATION 19A. DATE OF OPERATION 2- 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED - 20A. AUTOPSY? (Yes or No) YES 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? - (If in Baltimore City, give exact location) | | | | | | | | | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) - 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) - 21C. WHERE DID INJURY OCCUR? - (If in Baltimore City, give exact location) | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) - 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? - | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/15/1966 to 12/16/1966, that (I) (we) last saw the deceased alive on 12/16/1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | |
| 23A. SIGNATURE S. Mishkin M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> 23C. PHYSICIAN'S NAME (Type) S. Mishkin | | | | | | | | | | 23B. DATE SIGNED 12/16/66 | | | 23D. ADDRESS Johns Hopkins Hosp | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 24B. DATE 12/19/66 | | 24C. NAME OF CEMETERY or CREMATORY Church of Brethern Cemetery | | | 24D. LOCATION (City, town, or county) (State) Brownsville Maryland | | | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 20 1966 | | | 25B. NAME OF REGISTRAR R. E. Fisher | | | 25C. FUNERAL DIRECTOR Elva Tate | | | ADDRESS Brunswick Md. | | | | | | | |



1
M-60066 12704
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

66 12704

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN C. MURRAY

2. DATE AND HOUR PRONOUNCED DEAD

December 15, 1966 7:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

31 Baltimore City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

923 Bardswell Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married

8. DATE OF BIRTH

Feb. 1, 1919

9. AGE (In years
last birthday)

47

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Cork Mixer

10B. KIND OF BUSINESS OR INDUSTRY

Crown Cork & Seal

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

John Murray

14. MOTHER'S MAIDEN NAME

Ruth Thornton

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

yes

W.W. 11

16. SOCIAL
SECURITY NO.

214-03-7740

17. INFORMANT

ADDRESS

Anna J. Murray 923 Bardswell Rd.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/15/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Dec. 19/66

23C. NAME of CEMETERY or CREMATORY

Balto. National

23D. LOCATION

(City, town, or county)

(State)

Frederick Rd. Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

DEC 20 1966

Robert E. Fairbanks

KRAUSE FUNERAL HOME 1216S. Charles St

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|---|-----------------------------------|---|--|
| BIRTH NO. 66 12705 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 12705 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Herfurth, Jesse W.</i> | | 2. DATE AND HOUR OF DEATH <i>12/17/66 11:30 A.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <i>33 THE JOHNS HOPKINS HOSPITAL</i> (If not in hospital or institution, give street address or location) | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>CHESACO PARK (BALTIMORE Co.)</i> D. STREET ADDRESS (If rural, give location) <i>401 SEVERN AVENUE 53-00</i> | | | |
| 5. SEX <i>MALE</i> | 6. RACE <i>WHITE</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>MARRIED</i> | 8. DATE OF BIRTH <i>8-4-19</i> | 9. AGE (In years last birthday) <i>47</i> | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>CARPENTER</i> |
| 11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 13. FATHER'S NAME <i>OSCAR E. HERFURTH</i> | |
| 14. MOTHER'S MAIDEN NAME <i>EDNA E. LARKIN</i> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <i>Mrs. Mary K. Herfurth</i> | | ADDRESS <i>401 Severn Ave.</i> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>260X1</i> | | CAUSE OF DEATH (A) DUE TO <i>Acute myocardial infarction</i> (B) DUE TO <i>ASCUD</i> (C) DUE TO <i>Diabetes Mellitus</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>years</i> <i>years</i> | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>Yes</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (a) (this hospital) attended the deceased from <i>12/15/66</i> to <i>12/17/66</i> that (b) (we) last saw the deceased alive on <i>12/17/66</i> and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above. (d) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>W. H. Spencer</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>12/17/66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>W. H. Spencer 3rd</i> | | 23D. ADDRESS <i>Johns Hopkins Hospital</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 24B. DATE <i>12-20-66</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>BALTIMORE CEMETERY</i> | |
| 24D. LOCATION (City, town, & county) (State) <i>BALTO. MD.</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 20 1966</i> | | 25B. NAME OF REGISTRAR <i>R. B. E. Taylor</i> | |
| 25C. FUNERAL DIRECTOR <i>Heathly Miller</i> | | ADDRESS <i>2334 Jefferson St</i> | | | |

X

W.

E. LARKIN

E. HERBERT

CARPENTER

MARTLAND

Office, 18-20-22 Baltimore (C. & D. Co. Bldg.)
Baltimore, Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12706 | |
|--|--|--|--|---|--|
| 66 12706 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) | | ALBERT A. ARO | | 12/14/66 4:45 PM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY | |
| D.O.A. St. Agnes Hospital | | D.O.A. St. Agnes Hospital | | Md. Balt. Co. | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | |
| MALE | | WHITE | | MARRIED | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH | |
| | | BAL. GAS & ELECTRIC | | MAY 19, 1890 | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 9. AGE (In years last birthday) | |
| Unk | | Unk | | 76 | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 11. BIRTHPLACE (State or foreign country) | |
| YES WWI | | 212 05 5448 | | BALTIMORE, MD. | |
| 17. INFORMANT | | ADDRESS | | 12. CITIZEN OF WHAT COUNTRY? | |
| Mr. WILLIAM ARO | | 2971 BERO RD. | | U.S.A. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| Crown Thrombosis | | | | 2 hours | |
| 19. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from March 28 1966 to December 14 1966, that (I) (we) last saw the deceased alive on December 3 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | 23A. SIGNATURE | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | 12/16/66 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| BURIAL | | 12/19/66 | | BALTIMORE NATIONAL | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| | | | | McCULLY FUNERAL HOME #237 PATAPSCO AVE. | |
| 24D. LOCATION (City, town, or county) | | 24E. LOCATION (State) | | | |
| BALTIMORE, MD. | | | | | |

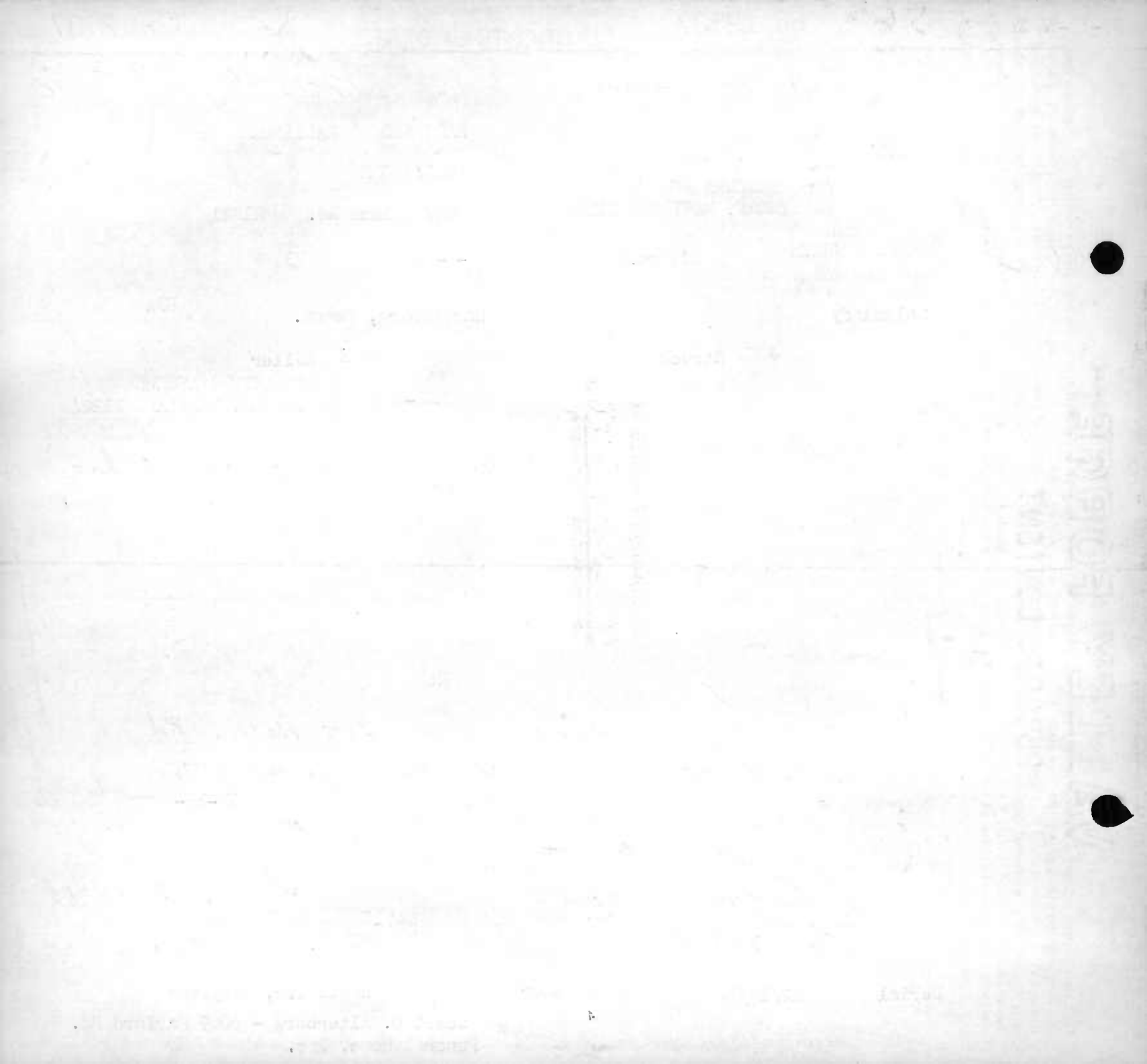
[The page contains extremely faint, illegible text, likely bleed-through from the reverse side. The text is scattered across the page and cannot be transcribed accurately.]

39-13-64 TN

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 563 66 12707 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12707 | |
|---|-------------------------|---|---|---|---|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Catherine Leonard</i> | | | | 2. DATE AND HOUR OF DEATH <i>12-13-66 9⁰⁰ P.M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>31</i> | | (If not in hospital or institution, give street address or location) <i>BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224</i> | | A. STATE <i>MARYLAND</i> | | B. COUNTY <i>BALTIMORE C.</i> | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i> | | <i>53-00</i> | |
| | | | | D. STREET ADDRESS (If rural, give location) <i>217 Helena Rd. 21221</i> | | | |
| 5. SEX <i>FEMALE</i> | 6. RACE <i>WHITE</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Divorced</i> | 8. DATE OF BIRTH <i>3-7-93</i> | 9. AGE (In years last birthday) <i>73</i> | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Saleslady</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Harrisburg, Penna.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> |
| 13. FATHER'S NAME <i>JOHN Strock</i> | | | 14. MOTHER'S MAIDEN NAME <i>MINNIE Miller</i> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | | 16. SOCIAL SECURITY NO. <i>405 83 9028A</i> | | 17. INFORMANT ADDRESS <i>4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224</i> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>E 916.0</i> | | | CAUSE OF DEATH <i>Extensive 63% Burns mostly full thickness</i> | | | INTERVAL BETWEEN ONSET AND DEATH <i>11 hrs.</i> | |
| 19A. DATE OF OPERATION <i>0</i> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) <i>NO</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Home</i> | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>217 Helena Rd 53-00</i> | |
| 21D. TIME OF INJURY (APPROX.) <i>12 15 66 10¹⁵ AM</i> | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? <i>Stove ignited clothes</i> | |
| 22. I certify that (a) (this hospital) attended the deceased from <i>12-13</i> 19 <i>66</i> to <i>12-15</i> 19 <i>66</i> , that (b) (we) last saw the deceased alive on <i>12-15</i> 19 <i>66</i> and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>A.T. Spear</i> | | | 23B. DATE SIGNED <i>12-13-66</i> | | | | |
| 23C. PHYSICIAN'S NAME (Type) <i>A.T. SPEAR</i> | | | 23D. ADDRESS <i>BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224</i> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12/19/66</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Moreland Memorial</i> | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 20 1966</i> | | 25B. NAME OF REGISTRAR <i>R. E. F.</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>Robert C. Altenburg - 6009 Harford Rd. Funeral Home, Inc.</i> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12708 | |
|--|-------------------------|---|-------------------------------------|---|---|
| BIRTH NO. 66 12708 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) JOHNSON MARSHELL H. | | 2. DATE AND HOUR OF DEATH 12/19/66 4:40 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | |
| FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital of Baltimore Inc 42 | | (If not in hospital or institution, give street address or location) | | D. STREET ADDRESS (If rural, give location) 2809 Allenale Rd #16 | |
| 5. SEX F | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 12/18/32 | 9. AGE (In years last birthday) 34 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) U.S.A (North Carolina) | |
| 13. FATHER'S NAME Rudolph Gillis | | 14. MOTHER'S MAIDEN NAME Lina Brown | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Edward Johnson 2809 Allenale Rd. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 170 X1 (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH (A) Terminal Carcinomosis DUE TO (B) Poorly differentiated DUE TO (C) CARCINOMA of Rt Breast | | INTERVAL BETWEEN ONSET AND DEATH 6 months | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 5/18/66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CA: Rt Breast | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from December 9, 1966 to December 19, 1966 , that (I) (we) last saw the deceased alive on December 19, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE E. D. Buffett | | | | 23B. DATE SIGNED 12/19/66 | |
| 23C. PHYSICIAN'S NAME (Type) FRITZ APOLLON | | | | 23D. ADDRESS M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/22/66 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore Natl Cem. | |
| 24D. LOCATION (City, town, or county) (State) 3501 Fredrick Ave. | | 25A. DATE REC'D BY HEALTH DEPT. DEC 20 1966 | | | |
| 25B. NAME OF REGISTRAR Clab E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR Frank T. Edickson 1129 N. Caroline St | | | |

Student
Richard Allen

12

Home Address
School from 11/1/1921

Home 12/30/21
School from 11/1/1921

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. 66 12709 | |
|---|--|------------------|--|--|--|--|--|--|--|---|--|
| BIRTH NO. 66 12709 | | | | | | | | | | | |
| M.E. CASE NO. (MARCIN) | | | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) MARTIN SMUTEK | | | | | | 2. DATE AND HOUR OF DEATH 12-18-66 7:30 P.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 35 Church Home & Hospital | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD B. COUNTY 21224 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 121 S. Linwood Ave. | | | | | |
| 5. SEX M | | 6. RACE W | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | | 8. DATE OF BIRTH 9-27-1900 | | 9. AGE (In years last birthday) 66 | | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BAKER | | | | 10B. KIND OF BUSINESS OR INDUSTRY OWN BAKERY | | 11. BIRTHPLACE (State or foreign country) POLAND | | | | 12. CITIZEN OF WHAT COUNTRY? POLAND | |
| 13. FATHER'S NAME JACOB SMUTEK | | | | | | 14. MOTHER'S MAIDEN NAME MARY PANKIEWICZ | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. 217-32-8005 | | 17. INFORMANT ANNA SMUTEK | | | | ADDRESS 121 S. LINWOOD AVE. 21224 | |
| 18. 10331 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Carcinoma, sigmoid & metastasis to liver | | | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH unknown | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Afterosclerosis, Generalized to Arteries, Chronic Gastritis, Encephalitis | | | | | | | | | | | |
| 19A. DATE OF OPERATION 2 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-5-66 19 66 to 12-18-66 19 66 , that (I) (we) last saw the deceased alive on 12-18 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE Rodolfo M. Lim | | | | | | M.D. Attending <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED 12-19-66 | |
| 23C. PHYSICIAN'S NAME (Type) Rodolfo M. LIM | | | | | | 23D. ADDRESS Church Home & Hosp. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | 24B. DATE 12-22-66 | | 24C. NAME OF CEMETERY or CREMATORY Holy Rosary Cem. | | | | 24D. LOCATION (City, town, or county) (State) Balto. Co. MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 20 1966 | | | | 25B. NAME OF REGISTRAR Robert E. Farley | | | | 25C. FUNERAL DIRECTOR W. Fialkowski | | | |
| | | | | | | ADDRESS 2007 Eastern Ave. 21231 | | | | | |

1900

1212
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Church

W

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BIRTH NO.

66 12710

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12710

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ARLENE

RAGLAND

2. DATE AND HOUR PRONOUNCED DEAD

December 17, 1966

2:25 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

CERTIFICATE AMENDED
 FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
 HOSPITAL OR ADDRESS OR LOCATION)
 INSTITUTION 1-17-67

222 N. Stricker Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

222 N. Stricker Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

2-21-1935

9. AGE (In years
last birthday)

31

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Unemployed

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Halifax Co. VA.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Victor Ragland

14. MOTHER'S MAIDEN NAME

Gladys Faulkner

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

unk

17. INFORMANT

ADDRESS

Mrs. Gladys Ragland 222 N. Stricker

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Idiopathic Myocardial Hypertrophy

(A) Bronchopneumonia
DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Acute and Chronic Pneumonitis

Idiopathic Myocardial Hypertrophy

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
 resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐
 ASSISTANT MEDICAL EXAMINER ☒
 ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/17/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12-21-66

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn

23D. LOCATION

(City, town, or county)

Baltimore

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

DEC 20 1966

24B. NAME OF REGISTRAR

Robert E. Farber

24C. FUNERAL DIRECTOR

Morton + Dyett 1701 LAURENS

ADDRESS

Letter from M.E.'s office 1-17-67 M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 12711 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12711 | |
|--|--|----------------------------------|---|-------------------------|--|
| M.E. CASE NO. | | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) TUTTLE, FRANCES | | | 2. DATE AND HOUR OF DEATH 12/17/66 7:30 A. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore General Hosp. | | | A. STATE Maryland B. COUNTY 25-32 Baltimore | | |
| 5. SEX Female | | | 6. RACE COLORED | | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED MARRIED | | | 8. DATE OF BIRTH 1-4-1911 | | |
| 9. AGE (In years last birthday) 55 | | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | |
| 11. BIRTHPLACE (State or foreign country) Newton, North Carolina | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME OTHA Mallins | | | 14. MOTHER'S MAIDEN NAME Lucy Whitenburg | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No. | | | 16. SOCIAL SECURITY NO. | | |
| 17. INFORMANT Mr. George Tuttle | | | ADDRESS 402 Seagull Ave. | | |
| 18. 4-20-11 | | | CAUSE OF DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | (A) Acute Myocardial Infarction DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) ASCVDs DUE TO "arteriosclerotic Cardiovascular Dis" | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | (C) Hypertensive Cardiovascular disease | | |
| 19A. DATE OF OPERATION 0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 20A. AUTOPSY? (Yes or No) 0 | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/16 19 66 to 12/17 19 66 , that (we) last saw the deceased alive on 12/17 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Rifat K. Alabousy | | | 23B. DATE SIGNED 12/17/66 | | |
| 23C. PHYSICIAN'S NAME (Type) Rifat K. Alabousy | | | 23D. ADDRESS 1213 Light Street Balto. Md. 21201 | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | 24B. DATE 12-20-66 | | |
| 24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cem. A.A. Co. Md. | | | 24D. LOCATION (City, town, or county) (State) | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 20 1966 | | | 25B. NAME OF REGISTRAR Robert E. Farber | | |
| 25C. FUNERAL DIRECTOR Morton E. Dyett F.H. | | | ADDRESS 1701 LAURENS | | |

LETTER, FRANCES

1911/12

Maryland

Baltimore

Not reading anymore

South Baltimore General Hall

Private Colored Library

22

1911/12

1911/12

1911/12

1911/12

1911/12

1911/12

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 66 12712 | |
|--|----------------------|---|--|--|--|--|----------------------------------|
| BIRTH NO. 8520 66 12712 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) MATTIE Jones | | 2. DATE AND HOUR OF DEATH 12 16 66 11:15 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 15-11 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 42 SINAI | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 3442 Delfield Ave | | | |
| 5. SEX F | 6. RACE N. | 7. <input checked="" type="checkbox"/> MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH 2.2.10 | 9. AGE (In years lost birthday) 56 | If Under 1 Yr. Months | If Under 24 Hrs. Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Wake Co., N.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Robert Keith | | | | 14. MOTHER'S MAIDEN NAME Viola Keith | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 238-K-6560 | | 17. INFORMANT Mr. Thomas Jones | | ADDRESS 3442 Delfield Ave | |
| 18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osleria, etc. It means the disease, injury or complication which caused death.) Diabetes Mellitus ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Heart failure | | | | CAUSE OF DEATH (A) P. Latentia DUE TO (B) Diabetes Mellitus DUE TO (C) Heart failure | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes) or No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12 16 19 66 to 12 16 19 66 , that (I) (we) last saw the deceased alive on 12 16 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE R. Theodore | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12 16 66 | |
| 23C. PHYSICIAN'S NAME (Type) ROGER THEODORE | | | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-21-66 | | 24C. NAME OF CEMETERY OR CREMATORY Pleasant Union Christian Em. Wake Co. | | 24D. LOCATION (City, town, or county) (State) N.C. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 20 1966 | | 25B. NAME OF REGISTRAR Robert E. Searcy, M.D. | | 25C. FUNERAL DIRECTOR Marlene Dyett F.H. | | ADDRESS 1701 Laurens St. | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

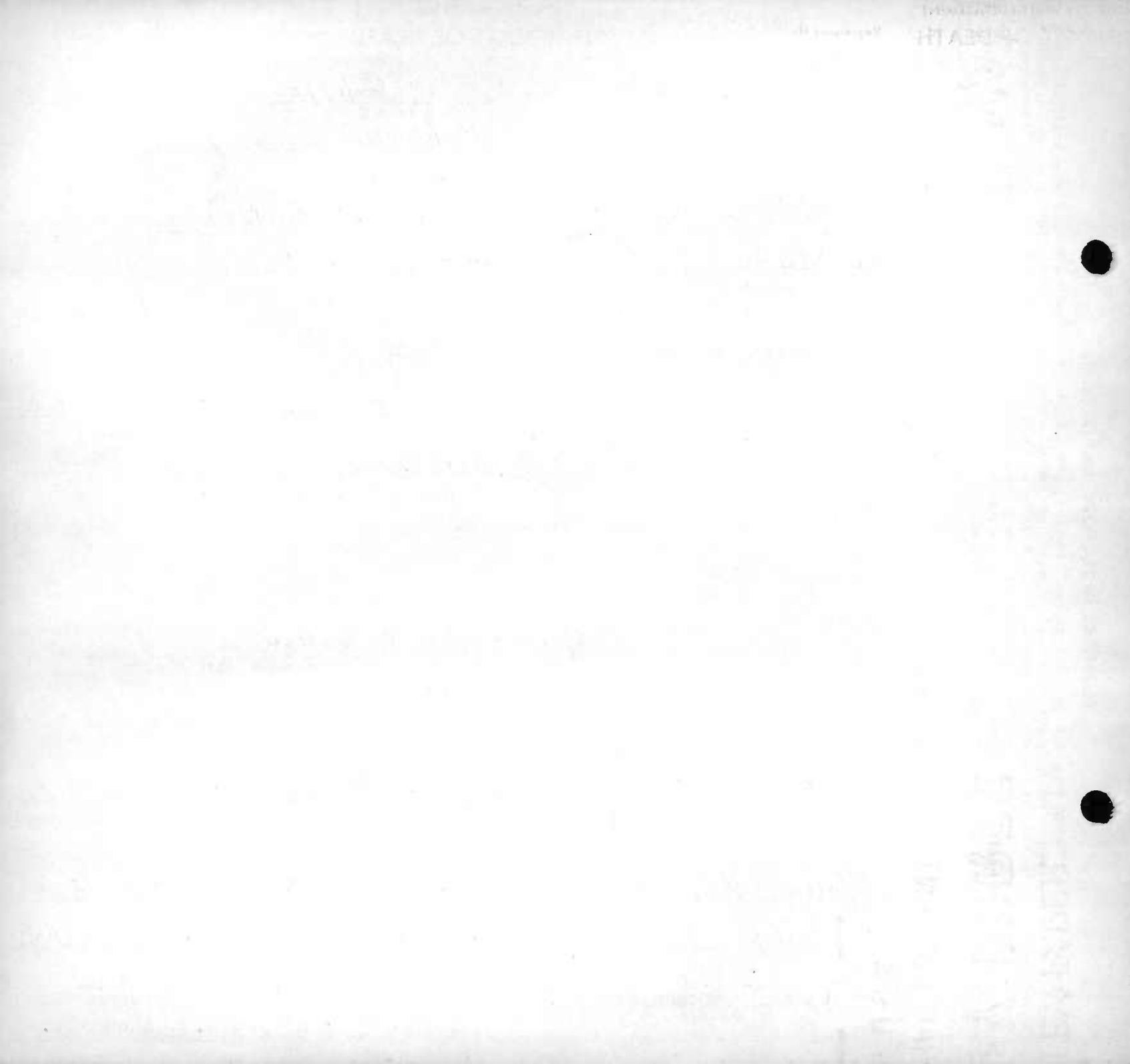
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 12713</u> | |
|---|---------------------|---|--|---|--|
| <div style="display: flex; justify-content: space-between;"> BIRTH NO. <u>66 12713</u> CERTIFICATE OF DEATH </div> | | | | | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <u>HARRISON, ARTHUR</u> | | | 2. DATE AND HOUR OF DEATH <u>12/18 66 4:15 P.M.</u> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>38 University Hospital</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>908 GILMORE ST (North)</u> | | |
| 5. SEX <u>M</u> | 6. RACE <u>N</u> | 7. MARRIED , NEVER MARRIED <u>WIDOWED</u> , DIVORCED (specify) | 8. DATE OF BIRTH <u>4/5/85</u> | 9. AGE (In years last birthday) <u>81</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 13. FATHER'S NAME <u>Emmanuel Harrison</u> | | | 14. MOTHER'S MAIDEN NAME <u>Caroline</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Eloise Harrison 908 Gilmore Street</u> | |
| 18. <u>433.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) <u>BRONCHOPNEUMONIA</u> DUE TO (B) <u>Cerebral emboli</u> DUE TO (C) <u>Chronic atrial fibrillation and atrial thrombus</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>11 weeks</u> <u>3 years</u> |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>12/4</u> 19 <u>66</u> to <u>12/18</u> 19 <u>66</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>12/18</u> 19 <u>66</u> and that in my (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>We</u>) (<u>did</u>) (<u>did not</u>) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Just P. Seigas</u> | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS <u>University Hospital Balto, Md #9</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12-22-66</u> | | 24C. NAME of CEMETERY or CREMATORY <u>New Catharal Cemetery</u> | |
| | | | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 20 1966</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR <u>George G. Kelson 1348 N. Calhoun St.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 66 12714 | |
|--|----------------------|---|--|---|--|--|--|
| BIRTH NO. 66 12714 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) LOFTON, BETTIE V. | | 2. DATE AND HOUR OF DEATH 12/19/66 11:35 AM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSPITAL OF MARYLAND | | | | A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 16-08 D. STREET ADDRESS (If rural, give location) 4104 FLOWERTON RD. | | | |
| 5. SEX FEMALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH 7-6-1890 | 9. AGE (In years last birthday) 76 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | |
| 10A. USUAL OCCUPATION | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) North Carolina | | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 13. FATHER'S NAME Robert Lofton | | | | |
| 14. MOTHER'S MAIDEN NAME Evelyn | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT Benny Hinnant - 4104 Flowerton Road | | | | |
| 18. 672.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Gastrointestinal Hemorrhage & Diverticulosis of colon | | | 19. CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | | | |
| 20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | 21. INTERVAL BETWEEN ONSET AND DEATH | | | | |
| 22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Conjunctive Heart failure | | | 23. MEDICAL CERTIFICATION | | | | |
| 24. DATE OF OPERATION | | | 25. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 26. AUTOPSY? (Yes or No) NO | |
| 27. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 29. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 30. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | 31. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 32. HOW DID INJURY OCCUR? | |
| 33. I certify that (I) (his hospital) attended the deceased from Nov 15 19 66 to Dec 19 19 66 , that (I) (we) last saw the deceased alive on Dec 19 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 34. SIGNATURE Young Kil Kim M.D. | | | | | | 35. DATE SIGNED 12/19/66 | |
| 36. PHYSICIAN'S NAME (Type) YOUNG KIL KIM M.D. | | | | | | 37. ADDRESS LUTHERAN HOSPITAL OF MARYLAND | |
| 38. BURIAL CREMATION, REMOVAL (Specify) Burial | | 39. DATE 12-22-66 | | 40. NAME OF CEMETERY or CREMATORY West Haven Cemetery | | 41. LOCATION (City, town, or county) (State) Wilson, North Carolina | |
| 42. DATE RECEIVED BY HEALTH DEPT. DEC 20 1966 | | 43. NAME OF REGISTRAR Robert E. Taylor | | 44. FUNERAL DIRECTOR George Kelson 1348 N. Calhoun St. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

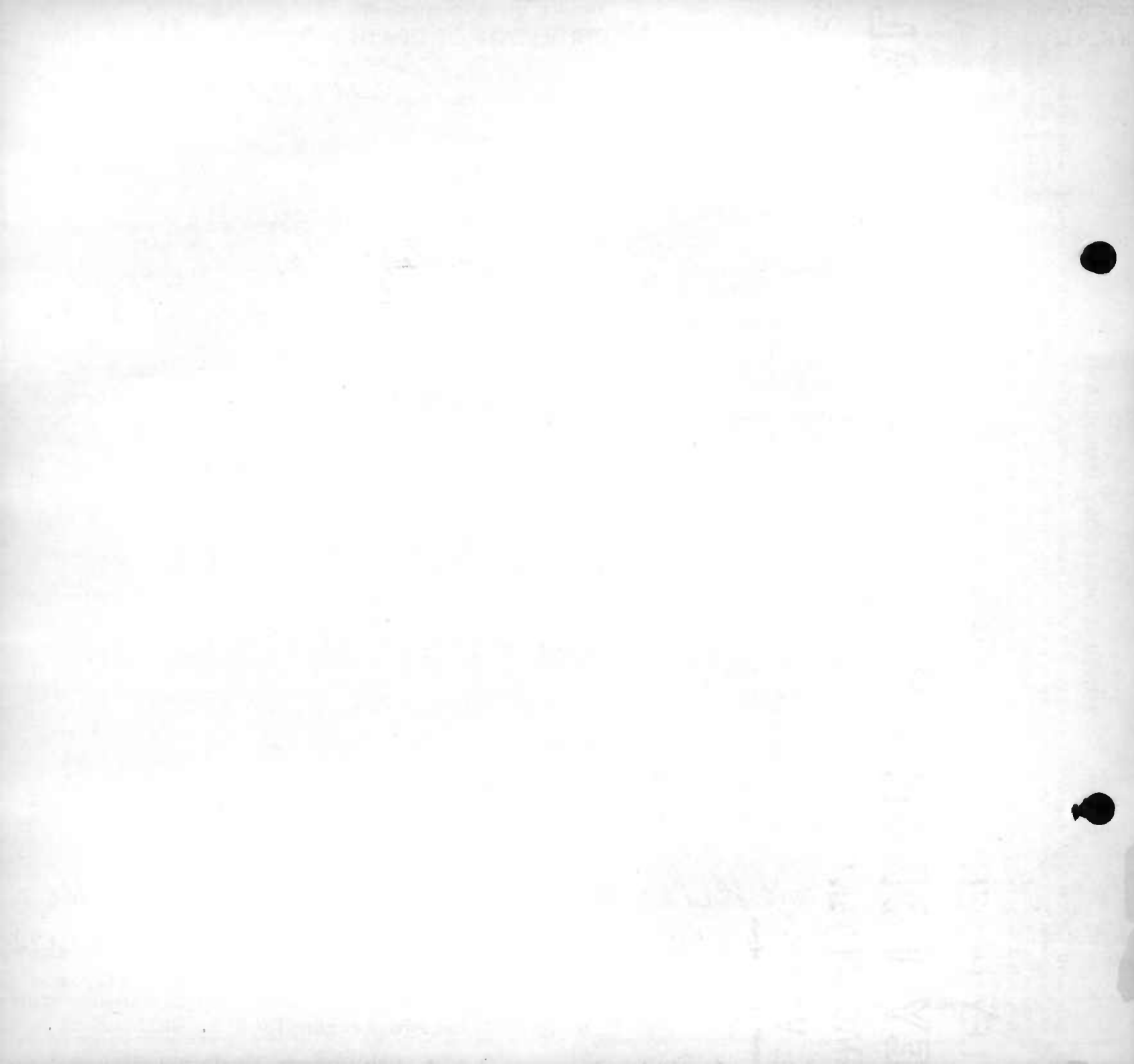
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12715 | |
|---|--------------------------------|--|--|---|---|
| <div style="display: flex; justify-content: space-between;"> BIRTH NO. 66 12715 CERTIFICATE OF DEATH </div> | | | | | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Joseph Parker | | | 2. DATE AND HOUR OF DEATH <div style="display: flex; justify-content: space-between;"> 12-18-66 11:15 P.M. </div> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND <div style="display: flex; justify-content: space-between;"> <div> FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital </div> <div> (If not in hospital or institution, give street address or location) </div> </div> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY _____ 5. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, 6. STREET ADDRESS (If rural, give location) 1416 N. Mount Street | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 4-12-1897 | 9. AGE (In years last birthday) 79 yrs. | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 13. FATHER'S NAME | | |
| 14. MOTHER'S MAIDEN NAME | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | |
| 16. SOCIAL SECURITY NO. 215-03-8905 | | | 17. INFORMANT Mrs. Susie Griffin - daughter | | |
| ADDRESS SAME | | | 18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 286.5 I Severe Malnutrition Dehydration </div> <div> INTERVAL BETWEEN ONSET AND DEATH </div> </div> | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |
| 19A. DATE OF OPERATION 0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 20A. AUTOPSY? (Yes or No) No | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>December 18, 1966</u> to <u>December 18, 1966</u>, that (I) (we) lost saw the deceased alive on <u>December 18, 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <div style="display: flex; justify-content: space-between;"> <div> 23C. PHYSICIAN'S NAME (Type) LAREDO </div> <div> 23D. ADDRESS M.D. </div> </div> | | | | | 23B. DATE SIGNED 12-19-66 |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-22-66 | | 24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. DEC 20 1966 | | | |
| 25B. NAME OF REGISTRAR Robert E. Talbot | | 25C. FUNERAL DIRECTOR George G. Kelson | | | |
| ADDRESS 1348 N. Calhoun St. | | | | | |

LAREDO

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

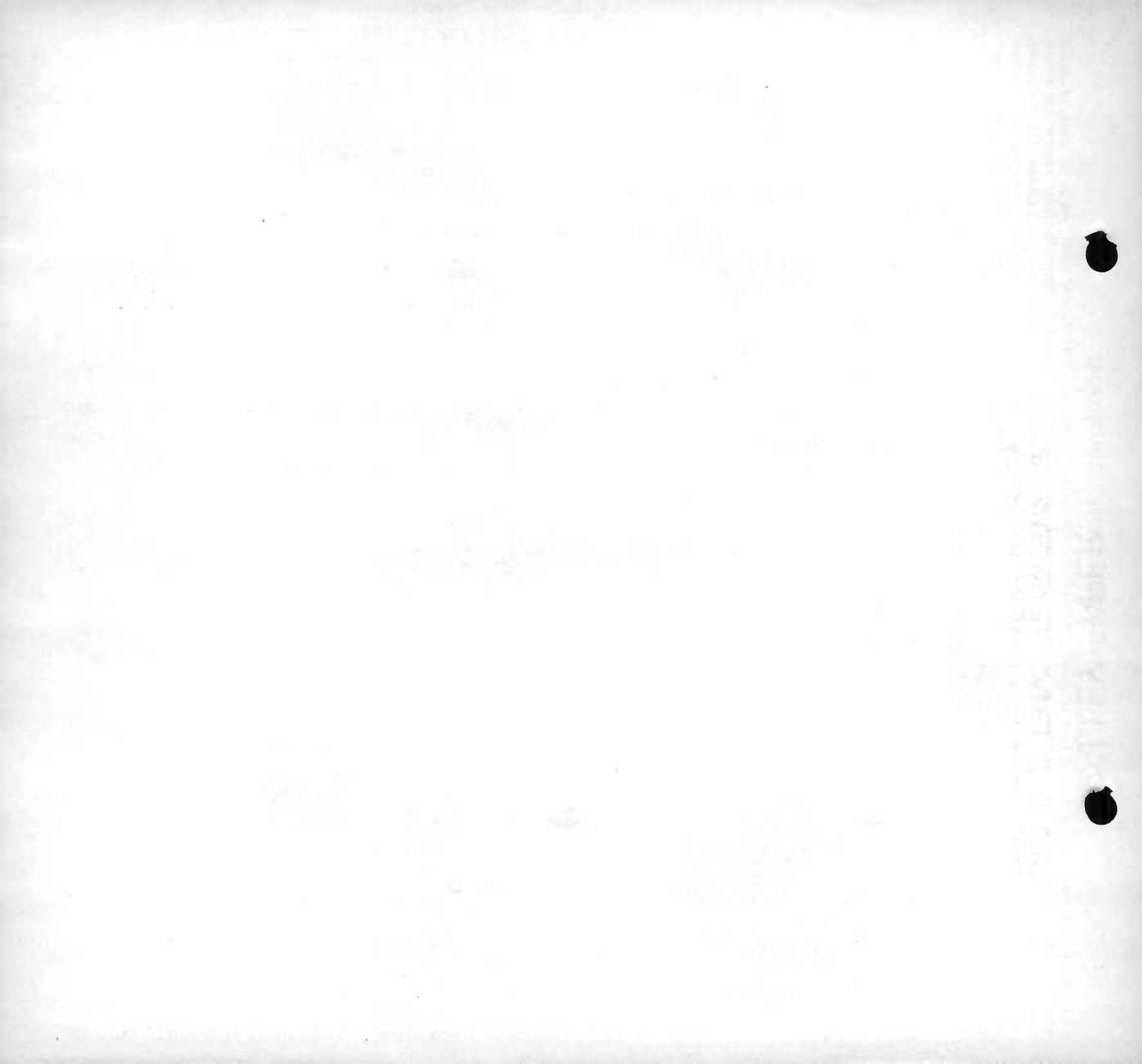
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 12716</u> | |
|---|--|--|--|---|--|
| BIRTH NO. <u>66 12716</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>LAWS, SUSIE J.</u> | | 2. DATE AND HOUR OF DEATH <u>Dec. 15 1966</u> <u>3:50 P.M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>46 LUTHERAN HOSPITAL OF MARYLAND</u> | | (If not in hospital or institution, give street address or location) | | D. STREET ADDRESS (If rural, give location) <u>620 N. FULTON AVE.</u> | |
| 5. SEX <u>FEMALE</u> | 6. RACE <u>NEGRO</u> | 7. MARRIED NEVER MARRIED <u>WIDOWED</u> (specify) | 8. DATE OF BIRTH <u>2/12/29</u> | 9. AGE (In years last birthday) <u>37</u> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>James Nickens</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Washington</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <u>Audrey Johnson 414 N. Payson Street</u> | |
| 18. <u>204.114260X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>LEUKEMIA (MYELOCYTIC)</u> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO | | (B) DUE TO | |
| (C) DUE TO | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Diabetes Mellitus</u> <u>Diverticulosis of colon</u> | | | |
| 19A. DATE OF OPERATION <u>0</u> | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) <u>No</u> | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Dec. 8</u> 19 <u>66</u> to <u>Dec. 15</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec. 15</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Young Kil Kim</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>12/15/66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>YOUNG KIL KIM</u> | | 23D. ADDRESS <u>LUTHERAN HOSPITAL OF MARYLAND</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | 24B. DATE <u>12-20-66</u> | 24C. NAME OF CEMETERY or CREMATORY <u>Church Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Lancaster County, Virginia</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>George Kelson 1348 N. Calhoun St.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| N-24 | | 66 12717 | | BALTIMORE CITY HEALTH DEPARTMENT | | REGISTERED NO. 66 12717 | |
| CERTIFICATE OF DEATH | | | | | | | |
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | | | Clara B. Nichols | | 12-17-66 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 1817 Smallwood Street | | | | A. STATE Maryland | | | |
| | | | | B. COUNTY | | | |
| 5. SEX Female | | | | 6. RACE Negroid | | | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) widowed | | | | 8. DATE OF BIRTH 12-25-84 | | 9. AGE (In years last birthday) 81 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME Charles Bell | | | | 14. MOTHER'S MAIDEN NAME Margaret | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. 217096081 | | 17. INFORMANT ADDRESS Clinton Nichols Sr. 1817 Smallwood | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 4 20.1 I CORONARY OCCLUSION | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH 1 day | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO Anteriosclerotic Cardiovascular Disease | | Unknown | |
| | | | | (C) Hypertension | | Unknown | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Nov 1962 to Dec 17 1966, that (I) (we) last saw the deceased alive on Dec 12 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE H. Garland Chissell Jr. M.D. | | | | 23B. DATE SIGNED 12-20-66 | | | |
| 23C. PHYSICIAN'S NAME (Type) H. Garland Chissell Jr. | | | | 23D. ADDRESS 1038 Edmondson Ave Baltimore Md | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-20-66 | | 24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Pk. | | 24D. LOCATION (City, town, or county) (State) Arbutus Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 20 1966 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR George G. Kelson | | ADDRESS 1348 Calhoun St. | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|
| 66 12/18 | | | | | 66 12/18 | | | | |
| BIRTH NO. | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | | 2. DATE AND HOUR OF DEATH | | | | |
| John Joseph Ludwig | | | | | 12-19-66 5:45 A.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 34 Bon Secours Hospital | | | | | MARYLAND BALTIMORE 20-05 | | | | |
| 5. SEX M 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21223 | | | | |
| 8. DATE OF BIRTH 1-27-1910 9. AGE (In years last birthday) 56 | | | | | D. STREET ADDRESS (If rural, give location) 335 S. Furrow Street | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MEAT PACKER | | | | | 10B. KIND OF BUSINESS OR INDUSTRY MEAT PACKING | | | | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | |
| 13. FATHER'S NAME ANTONE Ludwig | | | | | 14. MOTHER'S MAIDEN NAME MARGARET ? | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO NONE | | | | | 16. SOCIAL SECURITY NO. 213-09-9308 | | | | |
| 17. INFORMANT Ina Ludwig | | | | | ADDRESS 335 S. Furrow St. | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 443X1+260X | | | | | CAUSE OF DEATH (A) Acute pulmonary edema (B) Congestive heart failure (C) Hypertensive cardiomegaly, cardiovascular disease years | | | | |
| 19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | INTERVAL BETWEEN ONSET AND DEATH hours | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | Drab. mellitus | | | | |
| 19A. DATE OF OPERATION 2 | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | |
| 20A. AUTOPSY? (Yes or No) YES | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-19 1966 to 12-19 1966, that (I) (we) last saw the deceased alive on 12-19 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Octavio A. Ruiz | | | | | 23B. DATE SIGNED 12-19-66 | | | | |
| 23C. PHYSICIAN'S NAME (Type) Octavio A. Ruiz | | | | | 23D. ADDRESS Bon Secours Hospital | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | | 24B. DATE 12-22-66 | | | | |
| 24C. NAME OF CEMETERY or CREMATORY MEADOWRIDGE MEMORIAL | | | | | 24D. LOCATION (City, town, or county) (State) Howard City Md. | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 20 1966 | | | | | 25B. NAME OF REGISTRAR GEO. L. SCHWAB | | | | |
| 25C. FUNERAL DIRECTOR Francis J. Miller | | | | | ADDRESS 2101 Frederick Ave. | | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. 66 12719 | |
|--|--|---------------------|--|---|--|---|--|--|--|--|--|
| BIRTH NO. 66 12719 | | | | | | | | | | M.E. CASE NO. | |
| 1. NAME OF DECEASED (Type or Print) ARANOW, MOLLIE | | | | | | 2. DATE AND HOUR OF DEATH 12/19/66 5:30 A.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 SINAI HOSPITAL | | | | | | 4. USUAL RESIDENCE (Where deceased lived; If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 15-10 D. STREET ADDRESS (If rural, give location) 3928 RIDGEWOOD AVE. #15 | | | | | |
| 5. SEX F | | 6. RACE W | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH 1871 | | 9. AGE (In years last birthday) 95 | | 10. If Under 1 Yr. Months: Days: Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) RUSSIA | | | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | 13. FATHER'S NAME | | | | | |
| 14. MOTHER'S MAIDEN NAME | | | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | | |
| 16. SOCIAL SECURITY NO. | | | | | | 17. INFORMANT FRANK DONEN | | | | | |
| 18. ADDRESS SAME | | | | | | 19. CAUSE OF DEATH URINARY TRACT INFECTION + RENAL FAILURE 4 days + 2 days | | | | | |
| 20. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | 21. INTERVAL BETWEEN ONSET AND DEATH 4 days + 2 days | | | | | |
| 22. MEDICAL CERTIFICATION 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NO 20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | 21. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | |
| 21C. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | | | | 21D. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | | | | |
| 21E. HOW DID INJURY OCCUR? | | | | | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 11/29/1966 to 12/19/1966 that (I) (we) last saw the deceased alive on 12/19/1966 and that in (my) (our) opinion death occurred on the date and hour, and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE Hyman Greenfield M.D. | | | | | | 23B. DATE SIGNED 12/19/66 | | | | | |
| 23C. PHYSICIAN'S NAME (Type) HYMAN GREENFIELD M.D. | | | | | | 23D. ADDRESS SINAI HOSPITAL | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | 24B. DATE 12/20/66 | | 24C. NAME of CEMETERY or CREMATORY Mt Carmel | | | | 24D. LOCATION (City, town, or county) (State) Balto Md | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 20 1966 | | | | 25B. NAME OF REGISTRAR Robert E. Taylor | | | | 25C. FUNERAL DIRECTOR Sylvan S. Lewis & Son, Inc | | | |
| 25D. ADDRESS Olympia Ave | | | | | | | | | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|--|--|---|--|---|--|
| BIRTH NO. 66 12720 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12720 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) WALTER, HELEN M. WALTHER | | 2. DATE AND HOUR OF DEATH 12/16/66 2:00 PM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND CERTIFICATE AMENDED FULL NAME OF HOSPITAL OR INSTITUTION 46 LUTHERAN HOSPITAL OF MARYLAND (If not in hospital or institution, give street address or location) | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE | | 5. CITY OR TOWN (If outside city limits, write RURAL and give township) 24-02 | |
| 6. RACE WHITE | | 7. <input checked="" type="checkbox"/> MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH 9/21/17 | |
| 9. SEX FEMALE | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 11. BIRTHPLACE (State or foreign country) U.S. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Joseph P. Ross | | 14. MOTHER'S MAIDEN NAME Anna | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Family - Same | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) BRONCHOPNEUMONIA | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Diabetes mellitus HCLVD, obesity | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 20. MEDICAL CERTIFICATION 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec. 13 19 66 to Dec. 16 19 66 , that (I) (we) last saw the deceased alive on Dec. 16 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Young Kil Kim | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/18/66 | |
| 23C. PHYSICIAN'S NAME (Type) Young Kil Kim | | M.D. LUTHERAN | | 23D. ADDRESS 425 E. Gittings St. | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) 12/20/66 | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY Good Hope Park | |
| 24D. LOCATION (City, town, or county) (State) Baltimore | | 24E. DATE REC'D BY HEALTH DEPT. DEC 20 1966 | | 24F. NAME OF REGISTRAR Robert E. Talbot | |
| 24G. FUNERAL DIRECTOR W. A. Kelly | | 24H. ADDRESS 130 E. Tenth St. | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66-12721 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66-12721 | |
|--|--|--|--|--|--|---|--|
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <i>Bakey Bay Dixon</i> | | | | 2. DATE AND HOUR OF DEATH <i>6:20 AM 12/18/66 6:20 A M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND <i>Bakey Bay Dixon</i> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>md</i> B. COUNTY <i>Balto</i> | | | |
| 5. SEX <i>M</i> 6. RACE <i>W</i> 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>N M</i> | | | | 8. DATE OF BIRTH <i>12/17/66</i> 9. AGE (In years last birthday) <i>8</i> 10. MONTHS <i>56</i> | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i> | | | | 11. BIRTHPLACE (State or foreign country) <i>Balto md.</i> | | | |
| 13. FATHER'S NAME <i>John Dixon</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Karen Steiner same</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i> | | | | 16. SOCIAL SECURITY NO. <i>none</i> | | | |
| 17. INFORMANT <i>parents</i> | | | | ADDRESS | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osihenio, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES | | | | (A) DUE TO <i>Subarachnoid Bleed.</i> | | <i>3 hours</i> | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO <i>Aspiration pneumonia & angina</i> | | <i>6-9 hours</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | (C) <i>pernatuety</i> | | | |
| 19A. DATE OF OPERATION <i>none</i> | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>yes</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>none</i> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (In Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>12/17</i> 19 <i>66</i> to <i>12/18</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>12/18</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>W.E. Schwartz</i> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>12/18/66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>W.E. Schwartz</i> | | | | 23D. ADDRESS M.D. <i>Mercy Hospital</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12-19-66</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Lx</i> | | 24D. LOCATION (City, town, or county) (State) <i>BALTO MD</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 20 1966</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Schuma</i> | | 25C. FUNERAL DIRECTOR <i>C.F. Evans & Son</i> | | ADDRESS <i>8802 Harford Rd</i> | |

W. E. Schwartz
W. E. Schwartz

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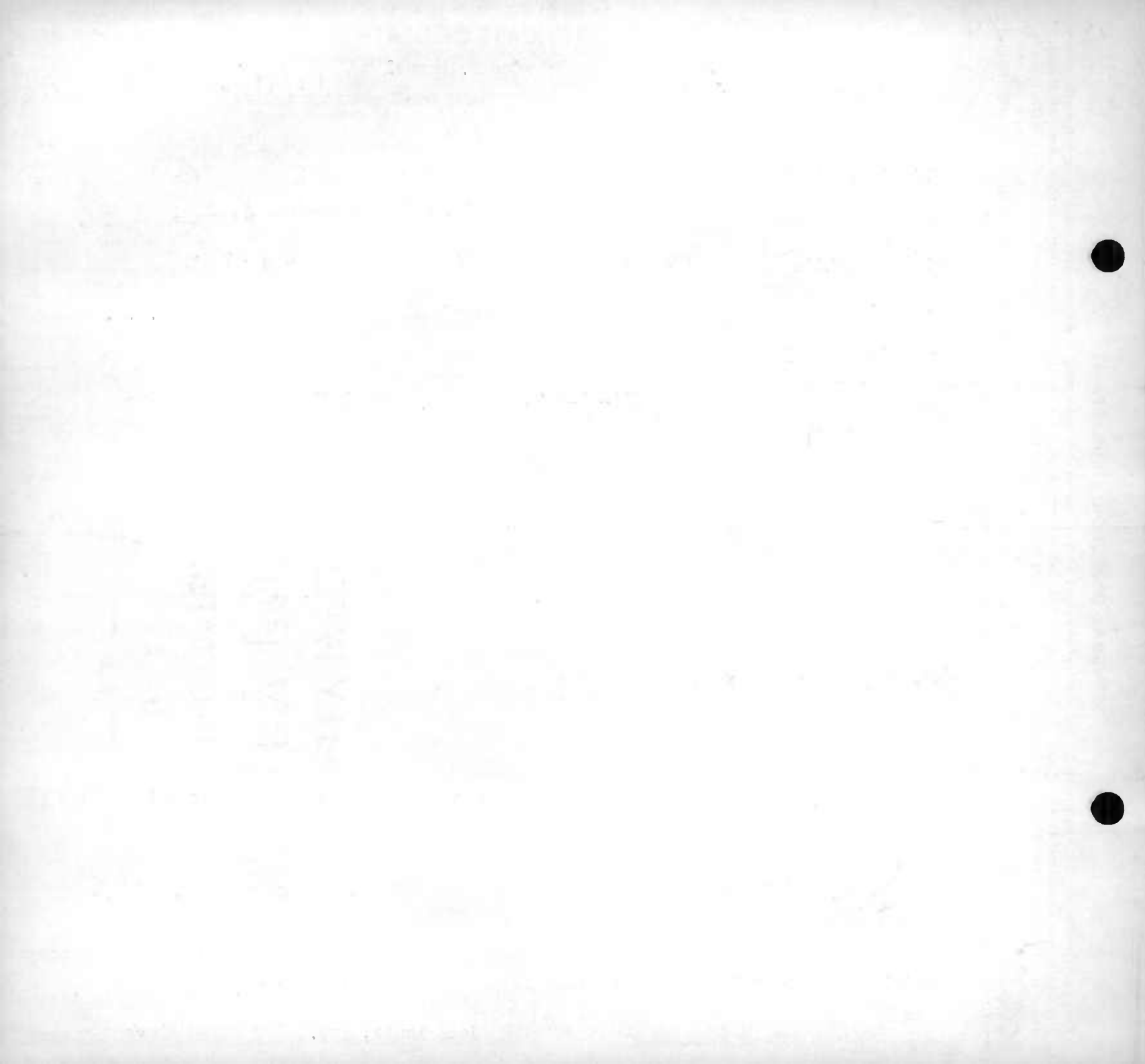
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W. E. Schwartz
W. E. Schwartz

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

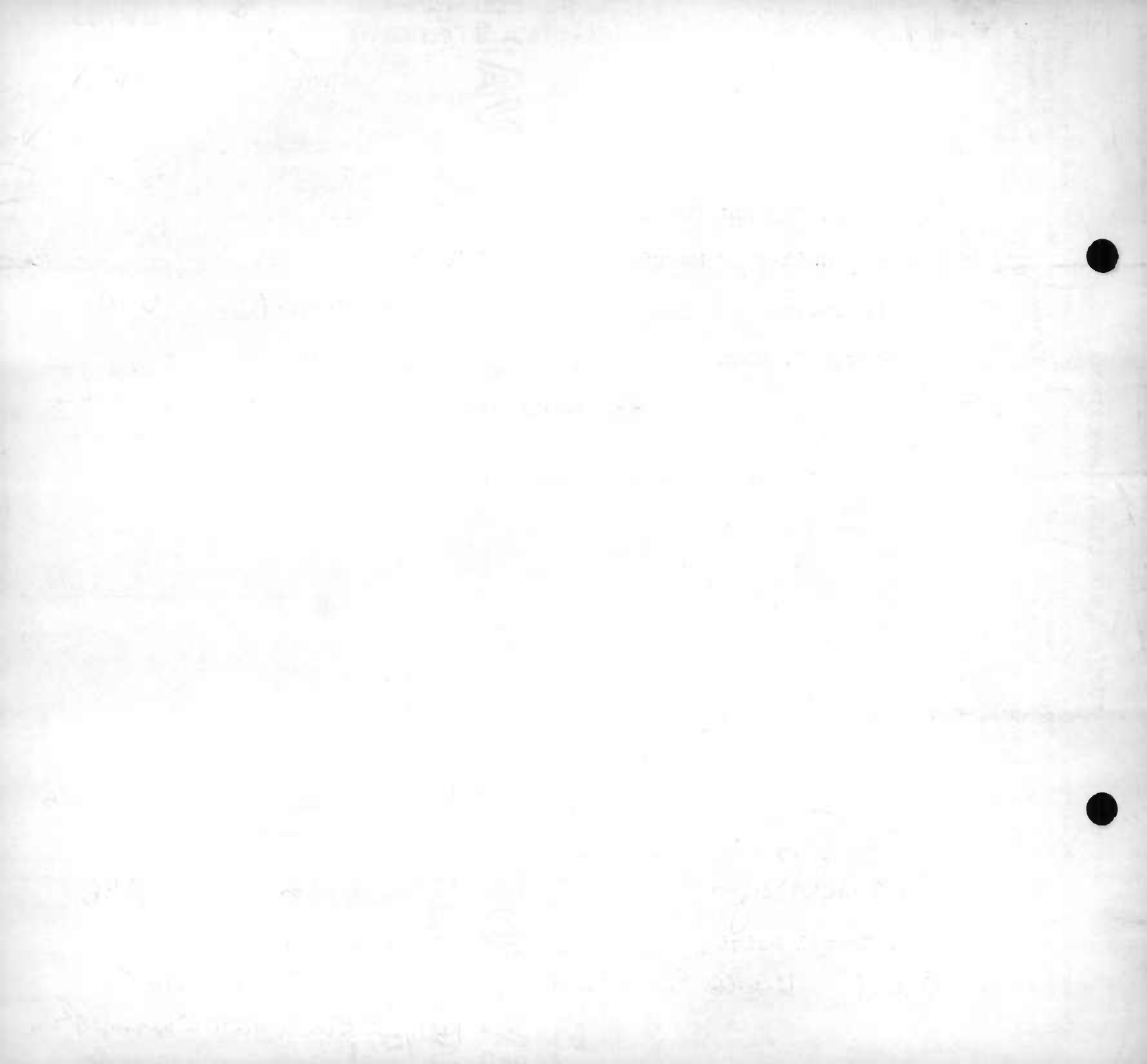
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|
| BIRTH NO. 66 12722 | | | | | CERTIFICATE OF DEATH | | Registered No. 66 12722 | | |
| M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) MANNEL F RAYMOND | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital | | | | | A. STATE MD | | | | |
| (If not in hospital or institution, give street address or location) | | | | | B. COUNTY | | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | | D. STREET ADDRESS (If rural, give location) | | | | |
| BALTIMORE | | | | | 3749 Columbus Drive | | | | |
| 5. SEX Male | | 6. RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | | 8. DATE OF BIRTH 1/16/99 | | 9. AGE (In years last birthday) 67 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Frederick Mannel | | | | | 14. MOTHER'S MAIDEN NAME Anna ? | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | | | | 16. SOCIAL SECURITY NO. 216-01-9272 | | 17. INFORMANT ADDRESS Dorothy Mannel 3749 Columbus Drive | | |
| 18. 134X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH (A) METASTATIC DISEASE DUE TO (B) Cancer of Rectum DUE TO (C) | | | | |
| INTERVAL BETWEEN ONSET AND DEATH 3 years | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION MARCH 1964 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED DUODENAL ULCER | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/23 19 66 to 12/19 19 66 , that (I) (we) last saw the deceased alive on 12/19 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Gordon | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED 12/19/66 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | 23D. ADDRESS M.D. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/21/66 | | 24C. NAME of CEMETERY or CREMATORY Har Sinai Cemetery | | 24D. LOCATION (City, town, or county) (State) Owings Mills, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 20 1966 | | 25B. NAME OF REGISTRAR R. E. FALCON | | 25C. FUNERAL DIRECTOR ADDRESS Jack Lewis, Inc. 2100 Eutaw Place | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|------------------------------|---|--|---|---|
| BIRTH NO. 66 12723 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12723 | |
| CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED (Type or Print) Theresa H. Neuman | | | 2. DATE AND HOUR OF DEATH 12/16/66 6⁰⁰A M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 The Johns Hopkins Hospital | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Balt. Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 8112 Edwell Avenue | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 7/14/29 | 9. AGE (In years last birthday) 37 | 10. Under 1 Yr. Months Days If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA. |
| 13. FATHER'S NAME George F. Zorn | | | 14. MOTHER'S MAIDEN NAME Mary Tucker | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 220-20-1054 | 17. INFORMANT George C. Newman ADDRESS 8112 Edwell Ave. | | |
| 18. 199.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Cancer | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) DUE TO (B) DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/14 1966 to 12/16 1966 , that (I) (we) last saw the deceased alive on 12/15 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE F. Ismail Beigi | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/16/66 |
| 23C. PHYSICIAN'S NAME (Type) F. Ismail Beigi | | | 23D. ADDRESS M.D. The Johns Hopkins Hospital | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 12-20-66 | 24C. NAME of CEMETERY or CREMATORY Secord Hunt of Jesus Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore Md | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 20 1966 | | 25B. NAME OF REGISTRAR Philip E. Fuchs | | 25C. FUNERAL DIRECTOR Philip E. Fuchs ADDRESS 1211 Cheseboro Ave | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 12724 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12724 | |
|---|-------------------------|--|--|--|--|---|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Mary E. Ellerbrock</i> | | | 2. DATE AND HOUR OF DEATH <i>15 Dec 1966 2 35 P.M.</i> | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</i> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>6-00</i> D. STREET ADDRESS (If rural, give location) <i>17 N. Montford Avenue 21224</i> | | | | |
| 5. SEX <i>Female</i> | 6. RACE <i>White</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i> | 8. DATE OF BIRTH <i>5-9-1889</i> | 9. AGE (In years lost birthday) <i>77</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | |
| 13. FATHER'S NAME <i>Charles WERNER</i> | | | 14. MOTHER'S MAIDEN NAME <i>Johanna-</i> | | | 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | | 16. SOCIAL SECURITY NO. <i>21403 5631B</i> | | 17. INFORMANT ADDRESS <i>RECORDS: BCH 4940 Eastern Avenue 21224</i> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>260X I</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) DUE TO <i>Cordiac Arrest</i> (B) DUE TO <i>ASCVD</i> (C) <i>Diabetes Mellitus</i> | | | INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i> <i>Years</i> <i>25 yrs</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>NO</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (we) (this hospital) attended the deceased from <i>29 Nov 1966</i> to <i>15 Dec 1966</i> , that (we) last saw the deceased alive on <i>15 Dec 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Dudley A. Raine, Jr.</i> | | | | 23B. DATE SIGNED <i>15 Dec 1966</i> | | | |
| 23C. PHYSICIAN'S NAME (Type) <i>Dudley A. Raine, Jr.</i> | | | | 23D. ADDRESS <i>4940 Eastern Avenue Baltimore, Maryland 21224</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12-19-66</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Holy Redeemer Cemetery</i> | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR <i>Robert E. Taylor</i> | | 25C. FUNERAL DIRECTOR <i>Philip F. Crach</i> | | ADDRESS <i>1211 Chesaca Ave</i> | |

Charles Amos

ASD V.D

Durham Wells

Quincy Adams

12 Dec 31

12 Dec 31

12 Dec 31

BIRTH NO. 66 12725

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12725

M.E. CASE NO.

| | | | |
|---|---|---|--|
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR PRONOUNCED DEAD | |
| LILLIE PEAKER | | December 14, 1966 4:50 A M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | |
| 00 579 Laurens Street | | | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | B. COUNTY | |
| A. STATE Maryland | | | |
| C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | | | |
| Baltimore | | 14-02 | |
| D. STREET ADDRESS (If rural, give location) | | | |
| 579 Laurens Street | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH |
| Female | Colored | Never Married | 02-09-99 |
| 9. AGE (In years last birthday) | | 10. KIND OF BUSINESS OR INDUSTRY | |
| 67 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 11. BIRTHPLACE (State or foreign country) | |
| Domestic Work | | Baltimore, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | |
| USA | | Phillip Peaker | |
| 14. MOTHER'S MAIDEN NAME | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) | |
| Louise Weeden | | No | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 215-07-9339 | | Mary E. Stokes 430 Orchard Street Baltimore, Md. | |
| 18. CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | |
| (A) Arteriosclerotic Cardiovascular Disease DUE TO | | | |
| (B) DUE TO | | | |
| (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| Diabetes Mellitus | | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 0 | | No | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | |
| 21D. TIME OF INJURY (APPROX.) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL EXAMINER'S NAME (Type) | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| Rudiger Breiteneker, M.D. | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DATE SIGNED | |
| | | 12/14/66 | |
| 23A. BURIAL CREMATION REMOVAL (Specify) | 23B. DATE | 23C. NAME OF CEMETERY or CREMATORY | 23D. LOCATION (City, town, or county) (State) |
| Burial | 12-19-66 | Mt. Auburn Cemetery | Baltimore, Maryland |
| 24A. DATE REC'D BY HEALTH DEPT. | 24B. NAME OF REGISTRAR | 24C. FUNERAL DIRECTOR | ADDRESS |
| DEC 20 1966 | R. E. E. E. E. | Bullock's Mortuary | 212-14 E. North Ave Baltimore, Md. |

WALLLEY PAPER

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FUNERAL DIRECTOR: IMPORTANT

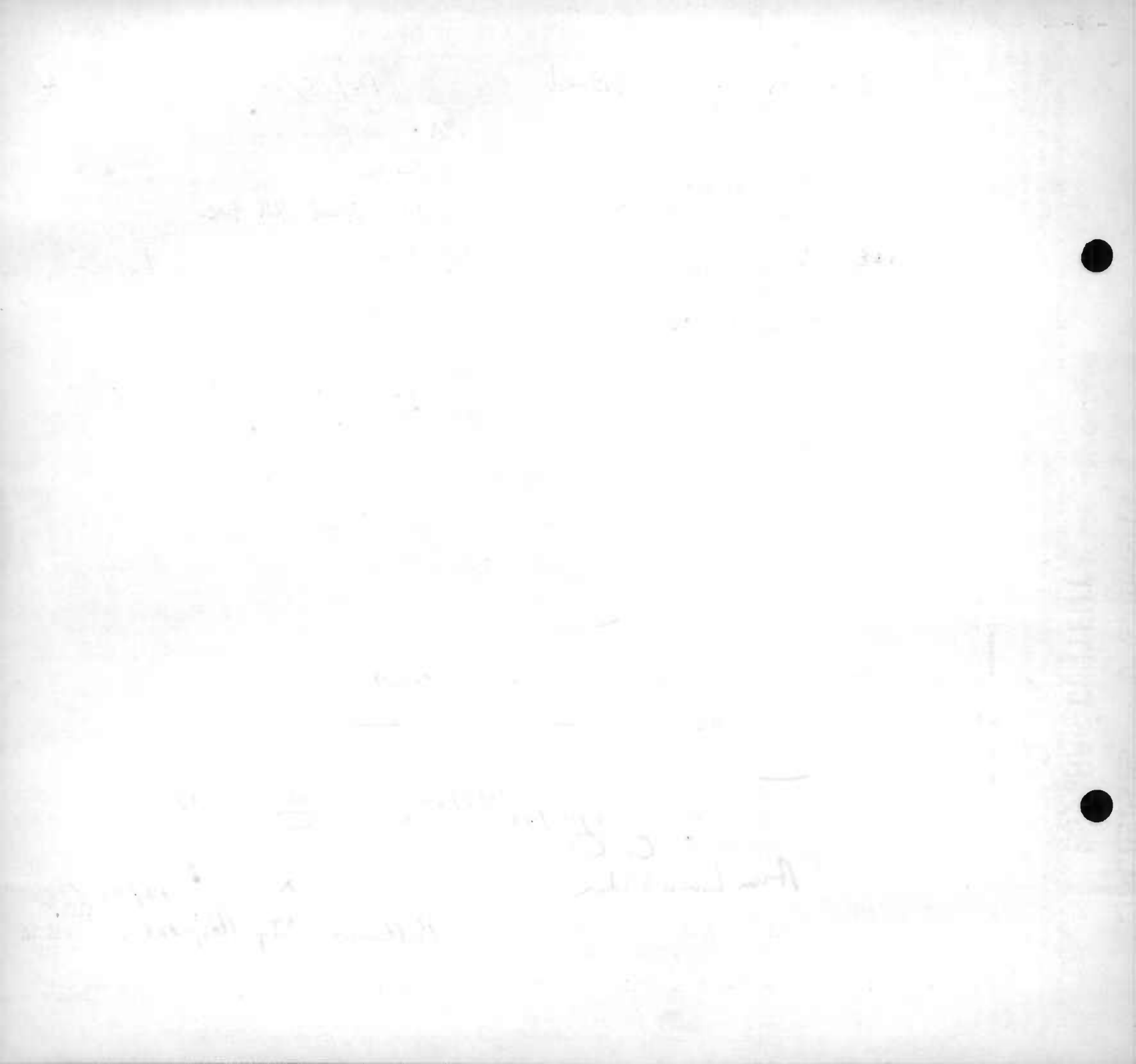
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|--|--|--|--|---|---|
| BIRTH NO. 66 12726 | | CERTIFICATE OF DEATH | | 66 12726 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | HICKS, baby girl | | Dec. 13, 1966 at 4:32 pm | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | M. | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| 31 Baltimore City Hospitals 4940 Eastern Avenue 21224 | | U.S.A. | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | 25-03 | |
| | | Baltimore Md. 21223 | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 2008 HOLLINS ST. | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months: Days: Hours: Min. |
| Female | negro | Single | Dec. 11, 1966 | 3 days | 0 3 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| NONE | | NONE | | Baltimore City Hospitals | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| NOT GIVEN | | LAVERNE | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| no | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 760.51 | | (A) prematurity | | 3 days | |
| ANTECEDENT CAUSES | | (B) CNS Hemorrhage | | ? | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) Benign resp. distress syndrome | | 3 days | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 2 none | none | yes | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | no | | | |
| 21D. TIME OF INJURY (APPROX.) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? | | | |
| no | While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec. 11 1966 to Dec. 13 1966, that (I) (we) last saw the deceased alive on Dec. 13 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| J. Wong | | | | 12/13/66 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| FRANK K. WONG | | Baltimore City Hospitals | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME of CEMETERY or CREMATORY | 24D. LOCATION (City, town, or county) (State) | | |
| Cremation | 12-15-66 | Baltimore City Hospitals | Baltimore Md 21224 | | |
| 25A. DATE REC'D BY HEALTH DEPT. | 25B. NAME OF REGISTRAR | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| DEC 20 1966 | John E. Talbot | HOSPITAL DISPOSAL | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

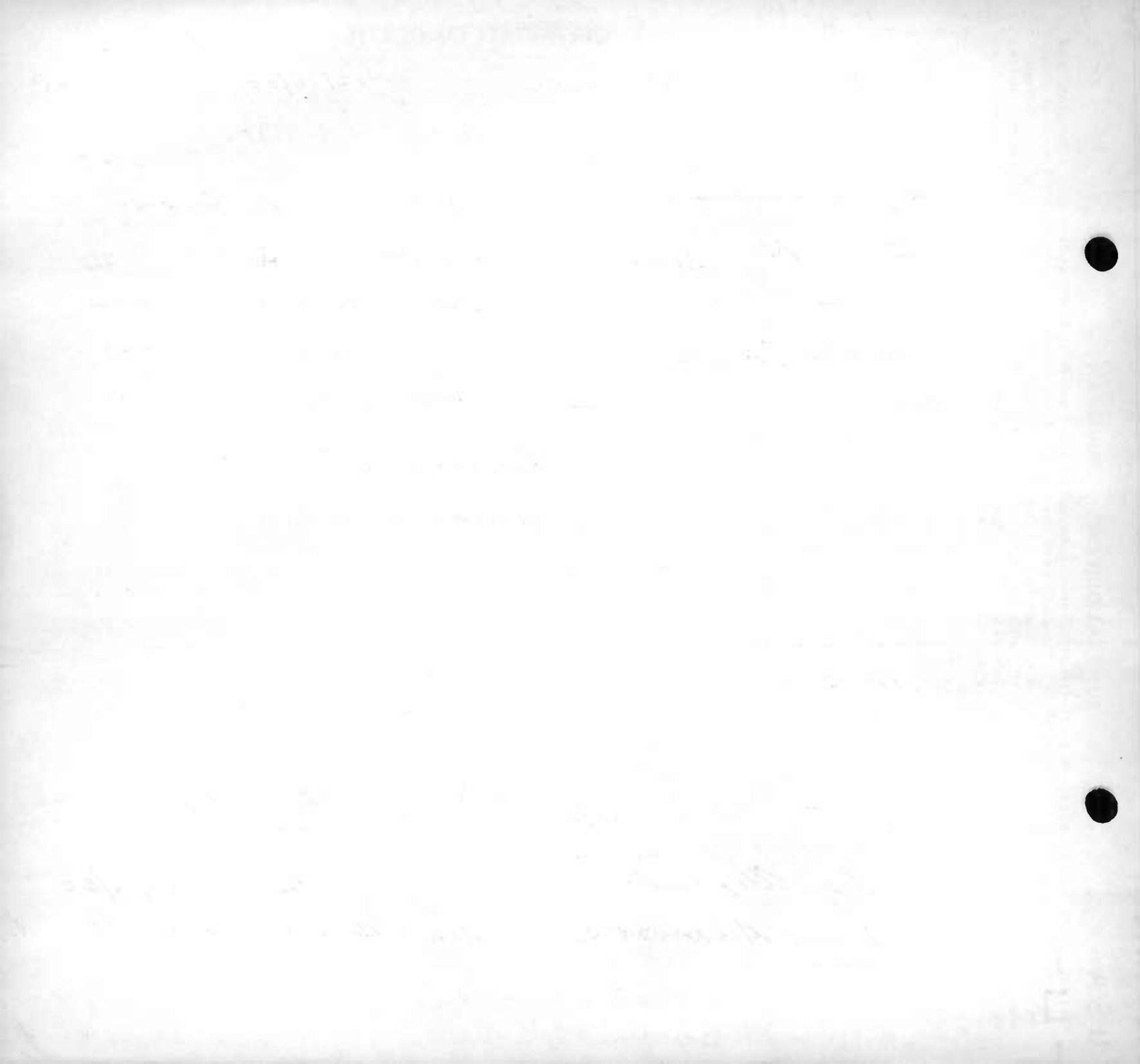
| | | | | | | | |
|---|---------------|--|--|---|-----------------------------------|---|--|
| BIRTH NO. | | M.E. CASE NO. 48 2542 | | CERTIFICATE OF DEATH | | Registered No. 66 12727 | |
| 1. NAME OF DECEASED (Type or Print) Bailey, Baby Boy - Mildred | | | | 2. DATE AND HOUR OF DEATH 12/15/66 3 ³⁵ A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals. 4940 Eastern Avenue 21224 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 14-02 D. STREET ADDRESS (If rural, give location) 1600 Druid Hill Ave. 21217 | | | |
| 5. SEX MALE | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never Married | | 8. DATE OF BIRTH 12/6/66 | 9. AGE (In years last birthday) 9 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME ? (lived & mother) | | | | 14. MOTHER'S MAIDEN NAME Mildred Bailey. | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT mother | | ADDRESS Records: BCH-4940 Eastern Avenue See above | |
| 18. 768.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH (A) hemorrhage DUE TO (B) possible sepsis DUE TO (C) amnionitis | | INTERVAL BETWEEN ONSET AND DEATH 19 hrs 3 days 9 days | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/6/66 to 12/15/66, that (I) (we) last saw the deceased alive on 12/15/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Ann Louise S Silver M.D. | | | | 23B. DATE SIGNED 12/15/66 | | | |
| 23C. PHYSICIAN'S NAME (Type) Ann Louise S Silver M.D. | | | | 23D. ADDRESS 4940 Eastern Avenue, Baltimore, Md. Baltimore City Hospitals 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Cremation | | 24B. DATE 12-15-66 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore City Hospitals | | 24D. LOCATION (City, town, or county) Baltimore, Maryland (State) 21224 | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 20 1966 | | 25B. NAME OF REGISTRAR Robert E. Bailey, M.D. | | 25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12728 | |
|---|---------------------|---|-------------------------------------|---|---|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 66 27033 66 12728 | | | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) TAYLOR, BABY GIRL | | 2. DATE AND HOUR OF DEATH 12/16/66 3⁰⁰ P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 33 JOHNS HOPKINS HOSPITAL | | A. STATE MD. B. COUNTY BALT. CITY | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city (limits, write RURAL and give township) BALTIMORE 15-09 | | | |
| | | D. STREET ADDRESS (If rural, give location) 2108 CHELSEA TERRACE | | | |
| 5. SEX F | 6. RACE N | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never married | 8. DATE OF BIRTH 12/15/66 | 9. AGE (In years last birthday) 20 HOURS | (If Under 1 Yr. Months Days Hours Min. 20 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY - | | 11. BIRTHPLACE (State or foreign country) BALTIMORE, MD. | |
| 13. FATHER'S NAME CHARLES TAYLOR | | 14. MOTHER'S MAIDEN NAME GERALDINE WOODEN | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. - | | 17. INFORMANT ADDRESS MOTHER ABOVE | |
| 18. 762.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) RESPIRATORY FAILURE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. APNEA SINCE BIRTH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 None | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/15 19 66 to 12/16 19 66 , that (I) (we) last saw the deceased alive on 12/16 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Duane Alexander M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED 12/16/66 | |
| 23C. PHYSICIAN'S NAME (Type) DUANE ALEXANDER M.D. | | | | 23D. ADDRESS JOHNS HOPKINS HOSPITAL, BALT, MD. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY J H H | |
| 24D. LOCATION (City, town, or county) (State) | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 20 1966 | | 25B. NAME OF REGISTRAR G. E. F. | | 25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL | |
| 25D. ADDRESS | | | | | |



66 12729

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12729

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN H. PALMER JR.

2. DATE AND HOUR PRONOUNCED DEAD

December 18, 1966 2:40 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

428 Worsley Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married

8. DATE OF BIRTH

Dec. 2, 1924

9. AGE (In years
last birthday)

42

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Bethlehem Steel

11. BIRTHPLACE (State or foreign country)

Reedsville, N.C.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John Palmer Sr.

14. MOTHER'S MAIDEN NAME

Mazzie Palmer

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

242-28-7487

17. INFORMANT

ADDRESS

Mrs. Mary Palmer 428 Worsley Street

18.

E 90010

CAUSE OF DEATH

Incised wound of right wrist with
almost complete transection of radial
arteryINTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(A) ~~XXXX~~

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

stairs

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

428 Worsley Street

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour) (Minute)
12-18-66 8:00 AM
2:00 PM

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Fell and cut wrist on mirror

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURECharles S. Springate, M.D.
EXAMINER'S NAME (Type)CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

December 19, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/22/66

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION (City, town, or county)

Reedsville, N.C.

(State)

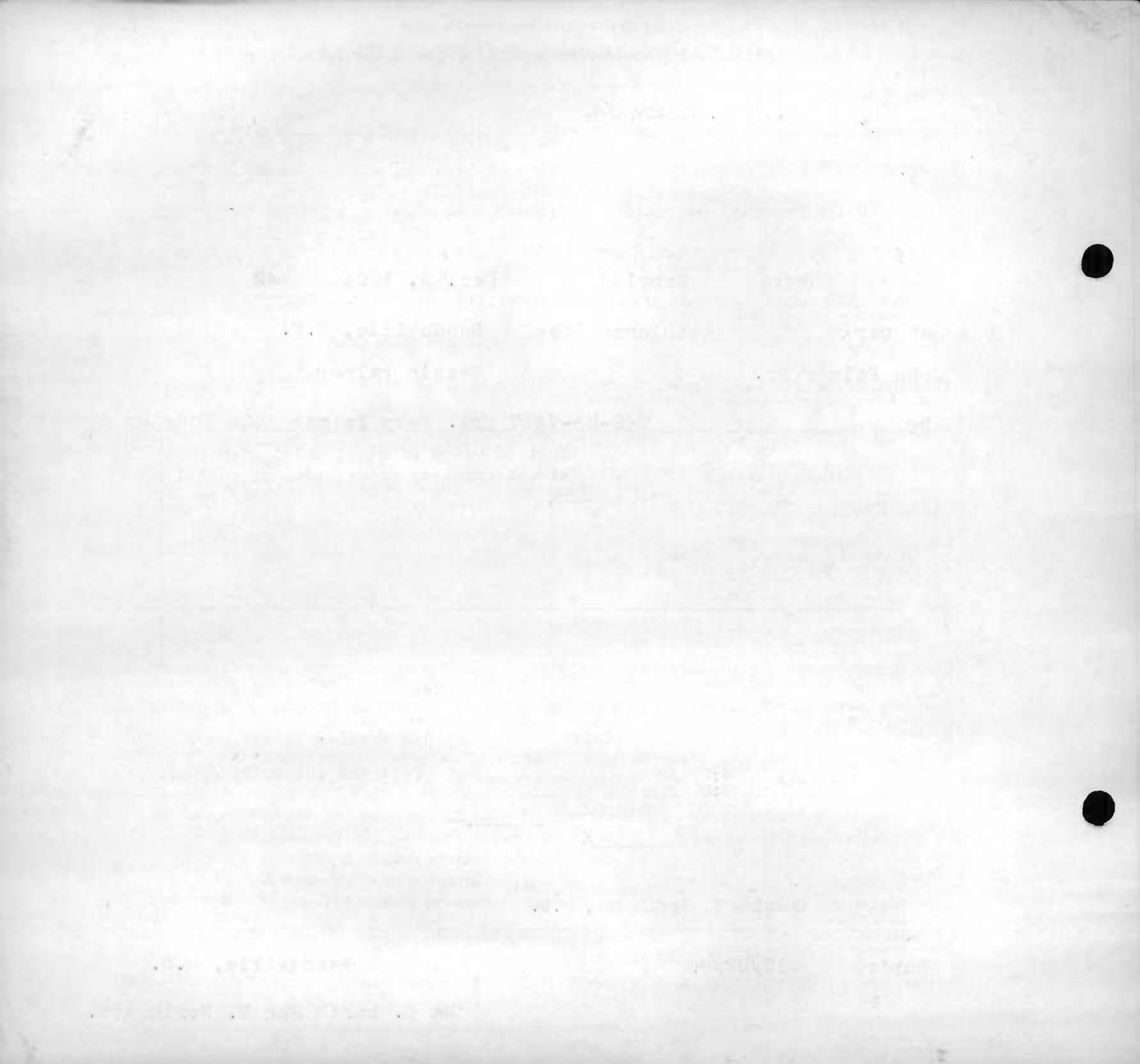
24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Wm C. March 928 E. North Ave.



66 12730

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12730

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

RACHEL C. BRYANT

2. DATE AND HOUR PRONOUNCED DEAD

December 17, 1966 7:00 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 924 W. Franklin Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1318 W. Lanvale Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

March 16, 1894

9. AGE (In years
last birthday)

72

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John Chase

14. MOTHER'S MAIDEN NAME

Ella Edwards

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Noris Watts 1318 W. Lanvale St

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic and Hypertensive
Cardiovascular Disease.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/17/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/21/66

23C. NAME OF CEMETERY or CREMATORY

Mt. Calvary Cem.

23D. LOCATION

(City, town, or county)

(State)

Cedar Hill Md.

24A. DATE REC'D BY HEALTH DEPT.

DEC 26 1966

24B. NAME OF REGISTRAR

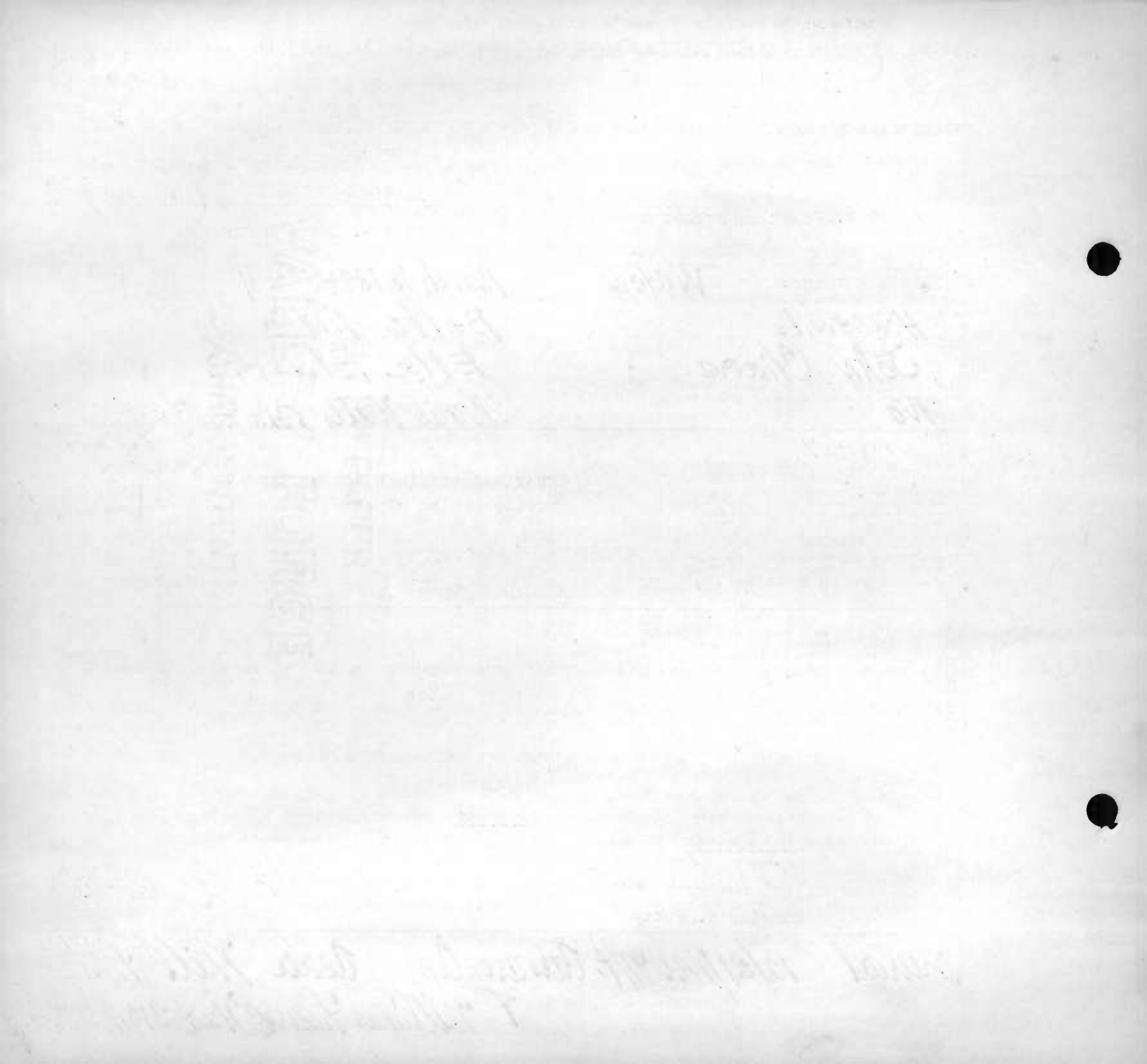
Robert E. Felt

24C. FUNERAL DIRECTOR

Williams Funeral Home

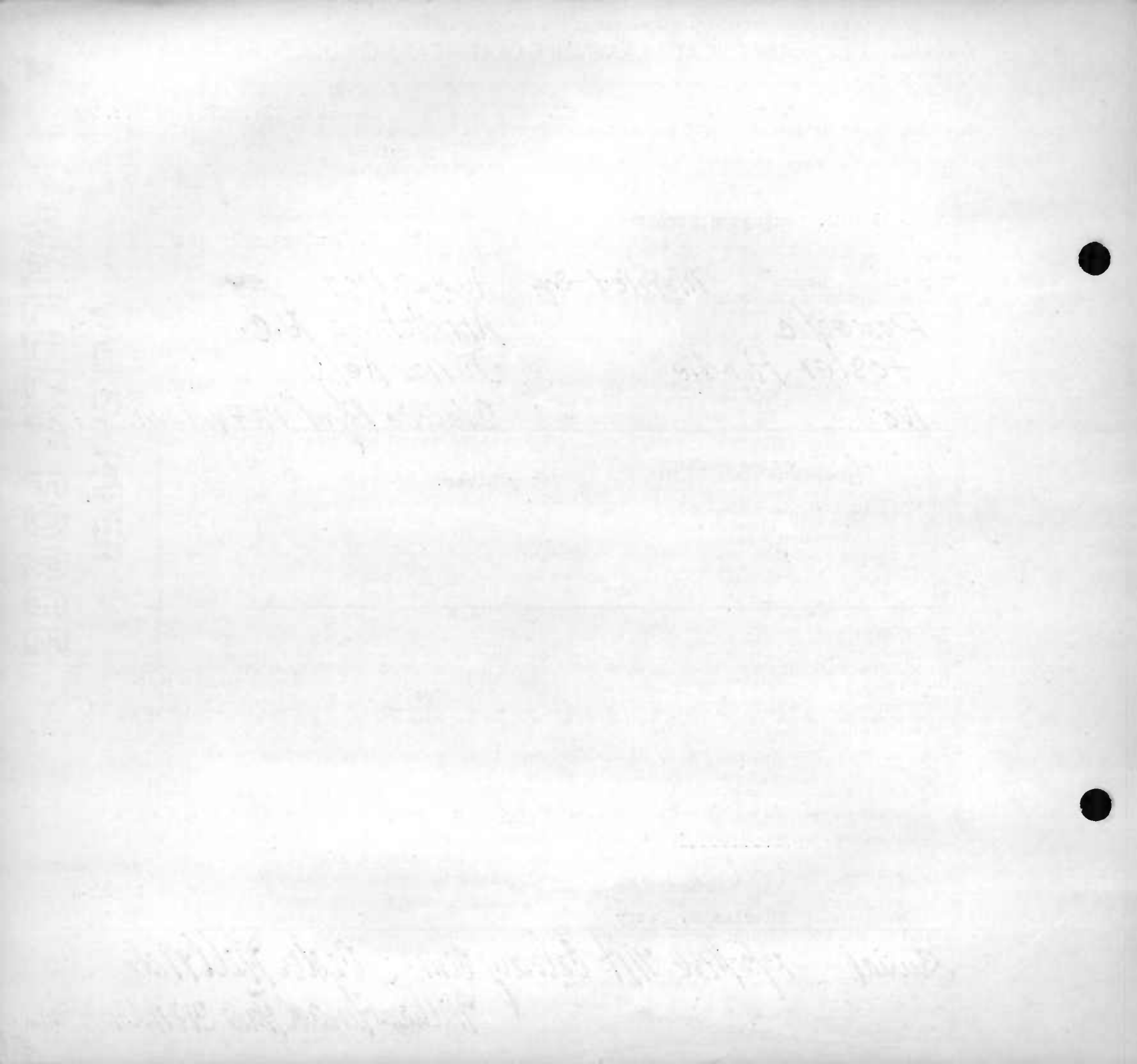
ADDRESS

319 N. Schrock St



BIRTH NO. 66 12731 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12731M-254
M.E. CASE NO.

| | | | | | |
|---|------------------|---|-----------------------------------|---|---|
| 1. NAME OF DECEASED (Type or Print) | | LEOLA McNEIL | | 2. DATE AND HOUR PRONOUNCED DEAD December 13, 1966 7:35 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 1700 W. Lexington Street | | A. STATE Maryland | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | B. COUNTY | | | |
| | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 1700 W. Lexington Street | | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married-Sep. | 8. DATE OF BIRTH Aug. 27, 1907 | 9. AGE (In years last birthday) 59 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Abbotsburg N.C. | |
| 13. FATHER'S NAME Foster Purdie | | 14. MOTHER'S MAIDEN NAME Julia Kelly | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Cleavie Byrd 1704 W. Lexington St. | |
| 18. 5810 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Fatty Liver. | | CAUSE OF DEATH (A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) DUE TO | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (C) DUE TO | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Yes | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE Charles S. Petty | | M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | Charles S. Petty | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | | DATE SIGNED 12/13/66 | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 12/20/66 | | 23C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cem. | |
| 23D. LOCATION (City, town or county) (State) Cedar Hill Md. | | 24A. DATE RECD BY HEALTH DEPT. DEC 26 1966 | | 24B. NAME OF REGISTRAR Robert E. Farber | |
| 24C. FUNERAL DIRECTOR William J. Howard | | 24D. ADDRESS 319 N. Schroeder St. | | | |



BIRTH NO. 66 12732 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12732
 M.E. CASE NO.

| | | | | | | | |
|---|---------|--|------------------|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR PRONOUNCED DEAD | | | |
| DORA WILLIAMS | | | | December 16, 1966 11:00 P M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | | | | |
| 38 University Hospital | | | | | | | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE | | | | | |
| Maryland | | B. COUNTY | | | | | |
| C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | | Baltimore | | | | | |
| D. STREET ADDRESS (If rural, give location) | | 629 W. Franklin Street | | | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | | |
| Female | Negro | Married | May 9, 1913 | 53 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Housewife | | | | | | Greensboro N.C. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Walter Metier | | | | Mattie Bryant | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | | | 917-22-9326 | | Clara Coleman 805 W. Lexington St | |
| 18. CAUSE OF DEATH | | | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | | | |
| (A) Carcinoma of Uterus. | | | | | | | |
| DUE TO | | | | | | | |
| (B) DUE TO | | | | | | | |
| (C) DUE TO | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 0 | | | | No | | | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| (Month) (Day) (Year) (Hour) | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | DATE SIGNED | |
| EXAMINER'S NAME (Type) | | M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | 12/17/66 | |
| ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | | 23C. NAME of CEMETERY or CREMATORY | | 23D. LOCATION (City, town, or county) (State) | |
| Burial | | 12/21/1966 | | Mt. Calvary Cem. | | Cedar Hill Md. | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | | 24C. FUNERAL DIRECTOR | | ADDRESS | |
| DEC 20 1966 | | Robert E. Fasham | | Williams Funeral Home | | 319 N. Schroeder St | |

WALTER POLICE

Walter H. Polk
Harrisburg, Pa.
Harrisburg, Pa.
Harrisburg, Pa.

Walter H. Polk
Harrisburg, Pa.
Harrisburg, Pa.
Harrisburg, Pa.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|---|------------------------------------|---|--|
| BIRTH NO. 66 12733 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12733 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Rossmark, George William</i> | | 2. DATE AND HOUR OF DEATH <i>12-17-66 7:55 A M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>BALTIMORE</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balt. Co.</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224</i> | | D. STREET ADDRESS (If rural, give location) <i>6934 RIVER DRIVE ROAD - 21219</i> | | | |
| 5. SEX <i>MALE</i> | 6. RACE <i>WHITE</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>MARRIED</i> | 8. DATE OF BIRTH <i>5/16/04</i> | 9. AGE (In years last birthday) <i>62</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 13. FATHER'S NAME <i>GEORGE WILLIAM ROSSMARK</i> | | 14. MOTHER'S MAIDEN NAME <i>LENA</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <i>213-07-6042</i> | | 17. INFORMANT ADDRESS <i>BCH, 4940 EASTERN AVENUE, BALTO., MD. 21224</i> | |
| 18. <i>420.1</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) <i>Overwhelming Pneumonia</i> DUE TO (B) <i>Internal R. Carotid artery occlusion</i> DUE TO (C) <i>Arteriosclerotic Cerebro-vasc. dis</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>4 da</i> <i>8 da</i> <i>unknown</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>12/13/66</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Tracheostomy for Aspiration Pneumonia</i> | | 20A. AUTOPSY? (Yes or No) <i>NO</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>no</i> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) <i>(this hospital)</i> attended the deceased from <i>9 Dec.</i> 19 <i>66</i> to <i>17 Dec</i> 19 <i>66</i> , that <i>(I) (we)</i> last saw the deceased alive on <i>12-17</i> 19 <i>66</i> and that in (my) <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>(We) (did)</i> (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>S. W. Douglas, M.D.</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>12-17-66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>S. W. DOUGLAS</i> | | 23D. ADDRESS <i>BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE, BALTIMORE, MD. 21224</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12-20-66</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Balto. Cemetery</i> | |
| 24D. LOCATION <i>MD.</i> | | 24E. LOCATION (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 21 1966</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Taylor</i> | | 25C. FUNERAL DIRECTOR <i>Thelma A. Hoffmann</i> | |
| 25D. ADDRESS <i>3218 Hudson St</i> | | | | | |

| | | |
|-------|--------------------------------------|--------------|
| 4 da | Overwhelming phenomena | Asymptomatic |
| 8 da | Intestinal ② Curved along occulum | |
| 10 da | Microscopic lesions - var. da | in brain |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| 35-15 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12734 | |
|--|-----------------------|---|-------------------------------------|--|---|
| BIRTH NO. 66 12734 | | CERTIFICATE OF DEATH | | Registered No. 66 12734 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Theodore Semiatin</u> | | 2. DATE AND HOUR OF DEATH <u>12/16/66</u> <u>10⁰⁵</u> <u>A</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>42 Sinai Hospital</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>27-20 6005 HIGHGATE DR.</u> | | | |
| 5. SEX <u>M</u> | 6. RACE <u>CAU</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>M</u> | 8. DATE OF BIRTH <u>10/30/96</u> | 9. AGE (In years last birthday) <u>70</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GROCER - Manager</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>FOOD FAIR</u> | | 11. BIRTHPLACE (State or foreign country) <u>POLAND</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>JOSEPH SEMIATIN</u> | | 14. MOTHER'S MAIDEN NAME <u>SARAH ?</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>415-12-1692</u> | | 17. INFORMANT <u>WIFE, Anna Semiatin,</u> | |
| 18. <u>493 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) <u>PNEUMONIA</u> DUE TO (B) _____ DUE TO (C) _____ | | ADDRESS <u>Same</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | <u>① Hypertensive ARTERIOSCLEROTIC CARDIOVASCULAR Dis</u> <u>② CHRONIC HEPATITIS</u> | | <u>YEARS</u> <u>2 YEARS</u> | |
| 19A. DATE OF OPERATION <u>None</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>None</u> | | 20A. AUTOPSY? (Yes or No) <u>None</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>None</u> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <u>(1)</u> (this hospital) attended the deceased from <u>12/7</u> 19 <u>66</u> to <u>12/16</u> 19 <u>66</u> , that <u>(1)</u> (we) last saw the deceased alive on <u>12/16</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>we</u>) (did) (not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>J. Brett Lazar</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>12/16/66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>J. BRETT LAZAR</u> | | 23D. ADDRESS <u>M.D. SINAI HOSP. OF BALT., INC.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12-18-66</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Forband</u> | |
| 24D. LOCATION <u>Baltimore, Maryland</u> | | 24E. STATE <u>Maryland</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 21 1966</u> | | 25B. NAME OF REGISTRAR <u>R. E. Johnson</u> | | 25C. FUNERAL DIRECTOR <u>Sol Levinson & Bros. Inc., 6010 Reisterstown</u> | |



1A-455

66 12735

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12735

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CLAIRE

Ena

MILLMAN

2. DATE AND HOUR PRONOUNCED DEAD

December 16, 1966

6:15 P

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

48 Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

13-02

D. STREET ADDRESS (If rural, give location)

2223 N. Eutaw Place

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

Aug-1910

9. AGE (In years
last birthday)

56

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Real estate

10B. KIND OF BUSINESS OR INDUSTRY

Proprietor

11. BIRTHPLACE (State or foreign country)

Baltimore, Md

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Harry Millman

14. MOTHER'S MAIDEN NAME

Esther

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown; If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

Unknown

17. INFORMANT

ADDRESS

Faye Miller - 4115 Newbern Ave

18.

296 X 1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Idiopathic Thrombocytopenia.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/17/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/18/66

23C. NAME OF CEMETERY or CREMATORY

Oh Knesseth Israel

23D. LOCATION (City, town, or county)

Baltimore, Md

24A. DATE REC'D BY HEALTH DEPT.

DEC 21 1966

24B. NAME OF REGISTRAR

Robert E. Fahren

24C. FUNERAL DIRECTOR

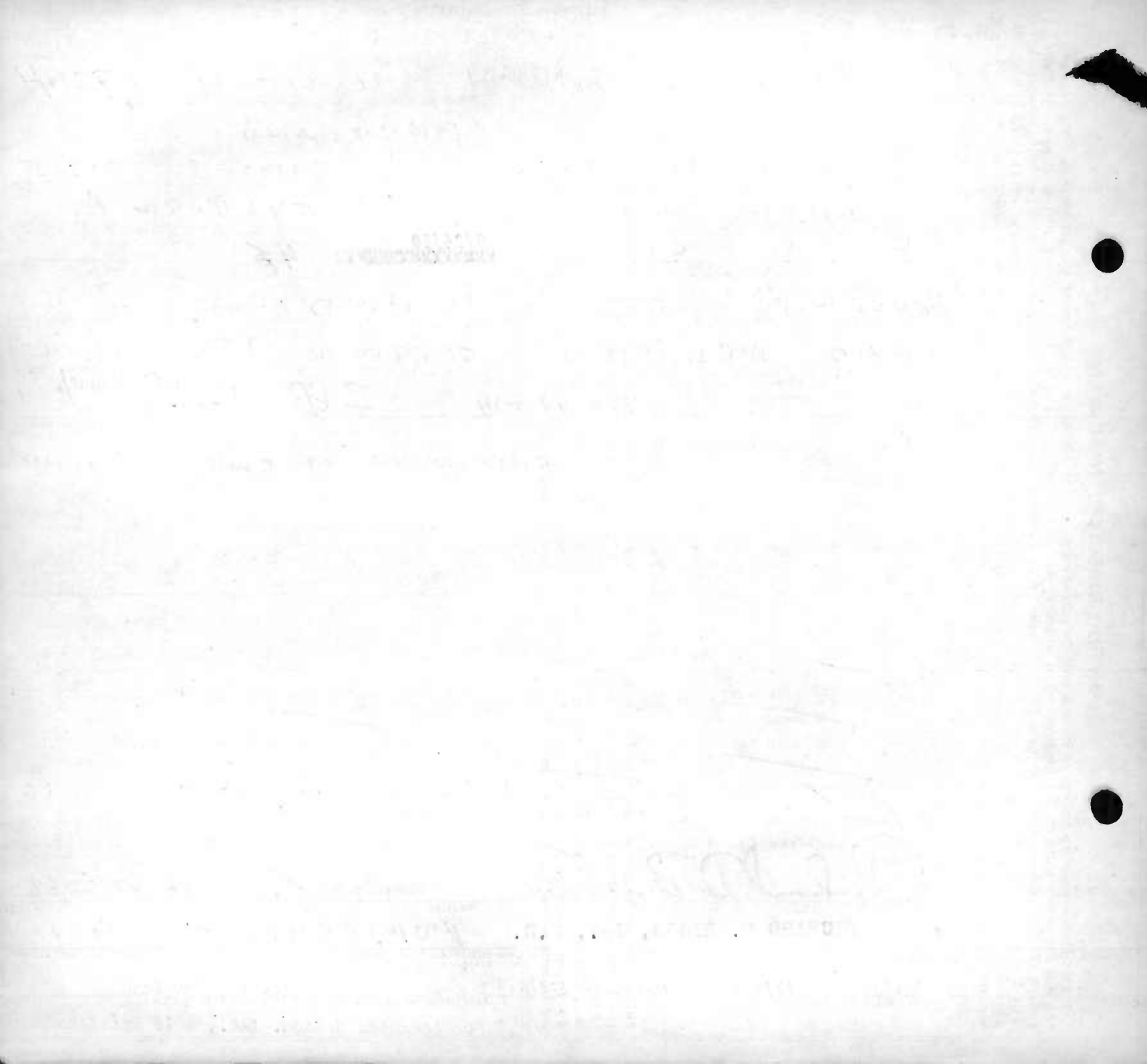
Sal Leunson & Bros - 6010 Reister Rd

ADDRESS

SALES FROM

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause at death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 12737</u> | |
|--|---------------------|---|---------------------------------------|--|---|
| BIRTH NO. <u>66 12737</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Charles Snyder</u> | | 2. DATE AND HOUR OF DEATH <u>Dec. 16, 1966</u> <u>9:30 P.M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Maryland General Hospital</u> <u>48</u> | | A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>13-01</u> D. STREET ADDRESS (If rural, give location) <u>2527 Brookfield Ave.</u> | | | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u> | 8. DATE OF BIRTH <u>11/15/1911</u> | 9. AGE (In years last birthday) <u>55</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>General Merchandise</u> | | 11. BIRTHPLACE (State or foreign country) <u>Russia</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>Unknown</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | | 17. INFORMANT <u>Mrs. Kropnick (daughter)</u> ADDRESS <u>2909 Fallstaff Rd</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>420.1 I</u> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) <u>Congestive Heart Failure</u> DUE TO | | <u>1 week</u> | |
| | | (B) <u>Myocardial Infarction</u> DUE TO | | <u>1 week</u> | |
| | | (C) <u>ASCVD</u> | | <u>years</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | <u>RUL pneumonia ; cerebrovasc. insuff. (old stroke)</u> | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Dec. 9</u> <u>1966</u> to <u>Dec. 16</u> <u>1966</u> , that (I) (we) last saw the deceased alive on <u>Dec. 16</u> <u>1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>W. Michael Gould</u> | | 23B. DATE SIGNED <u>12/16/66</u> | | 23C. PHYSICIAN'S NAME (Type) <u>Dr. W. Michael Gould</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12/19/66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>(Aitz Chaim) - Anshe Emunah</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 21 1966</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Johnson</u> | |
| 25C. FUNERAL DIRECTOR <u>Sol Levinson & Bros. Inc., 6010 Reisterstown</u> | | 25D. ADDRESS | | | |

Maryland General Hospital

M W andover

Baltimore
5253 Brookfield Ave

4/2/53 6:30

Maryland

Mr. Knapp
(Manager)

Conjunctive Heart Failure

Myocardial Infarction

ASCVHD

All symptoms 2 (old stroke)
Cardiac arrest

Dec 16

Dec 9

Dec 10

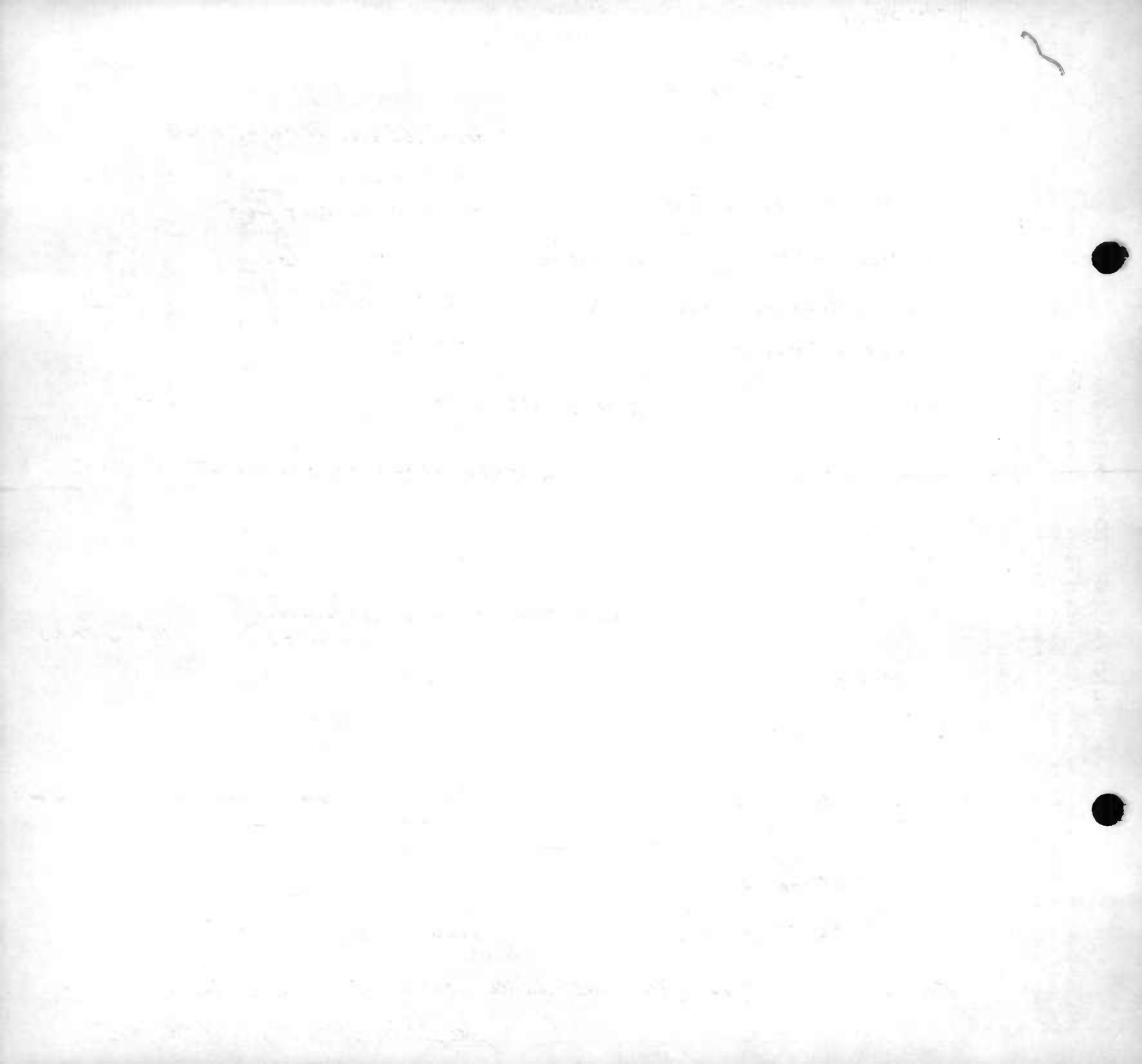
W. Michael Gould

X

12/16/53

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------------------|--|---|---|--|
| BIRTH NO. 66 12739 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12739 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) HERMAN TAYLOR | | 2. DATE AND HOUR OF DEATH 12-12-66 4:20 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) FRANKLIN SQUARE HOSP. 36 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY MARYLAND C. CITY OR TOWN (If outside city limits, write suburb and give township) BALTIMORE 19-02 D. STREET ADDRESS (If rural, give location) 223 N. GILMORE ST. | | | |
| 5. SEX M | 6. RACE N | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SEPARATED | 8. DATE OF BIRTH SEP. 11, 1916 | 9. AGE (In years lost birthday) 52 | If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) NORTH CAROLINA | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME HARDY TAYLOR | | | 14. MOTHER'S MAIDEN NAME KORENA SUGGS | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) INTERNAL HEMORRHAGE GASTRIC PEPTIC ULCER ARTERIOSCLEROTIC CORONARY HEART DISEASE, SEVERE | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CHF MYOCARDIAL ISCHEMIA | | | | | |
| 19A. DATE OF OPERATION 11-18-66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED BLEEDING GASTRIC ULCER | | 20A. AUTOPSY? (Yes or No) yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 11-10-66 to 12-12-66 19 66 that (I) (we) last saw the deceased alive on 12-12-66 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Caplan | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-12-66 | |
| 23C. PHYSICIAN'S NAME (Type) HILARIOSA L. GILTZ | | 23D. ADDRESS M.D. FRANKLIN SQUARE HOSP. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 12-20-66 | 24C. NAME OF CEMETERY OR CREMATORY Arlington Natl Cemetery, | | 24D. LOCATION (City, town, or county) (State) Arlington, Virginia | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 21 1966 | | 25B. NAME OF REGISTRAR R. E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS John T. Rhine Co. | |

John T. Kline

1
M-600

66 12740

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 12740

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LACEY VAN BUREN MURROW

2. DATE AND HOUR PRONOUNCED DEAD

December 16, 1966 10:55 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

28 W. Baltimore Street,
Lord Baltimore Hotel

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE D.C.

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Washington

D. STREET ADDRESS (If rural, give location)

3012 Cortland Place, N.W.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

June 30, 1904

9. AGE (In years
last birthday)

62

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Self Employed

10B. KIND OF BUSINESS OR INDUSTRY

Civil Engineer

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Rosco C. Murrow

14. MOTHER'S MAIDEN NAME

Ethel Lamb

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

W.W.II

16. SOCIAL
SECURITY NO.

726-05-7555

17. INFORMANT

ADDRESS

Margaret L. Murrow, Same as #4

18.

E 976 X 1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) _____
DUE TO

Shotgun wound of chest

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

hotel room

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Lord Baltimore Hotel

Room #1426 28 W. Baltimore Street

21D. TIME
OF INJURY
(APPROX.)12-15-66 or
12-16-66 ?

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot self with shotgun

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURECharles S. Springate, M.D.
EXAMINER'S NAME (Type)CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

December 16, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/20/66

23C. NAME OF CEMETERY or CREMATORY

Arlington National

23D. LOCATION

(City, town, or county)

(State)

Arlington, Virginia

24A. DATE REC'D BY HEALTH DEPT.

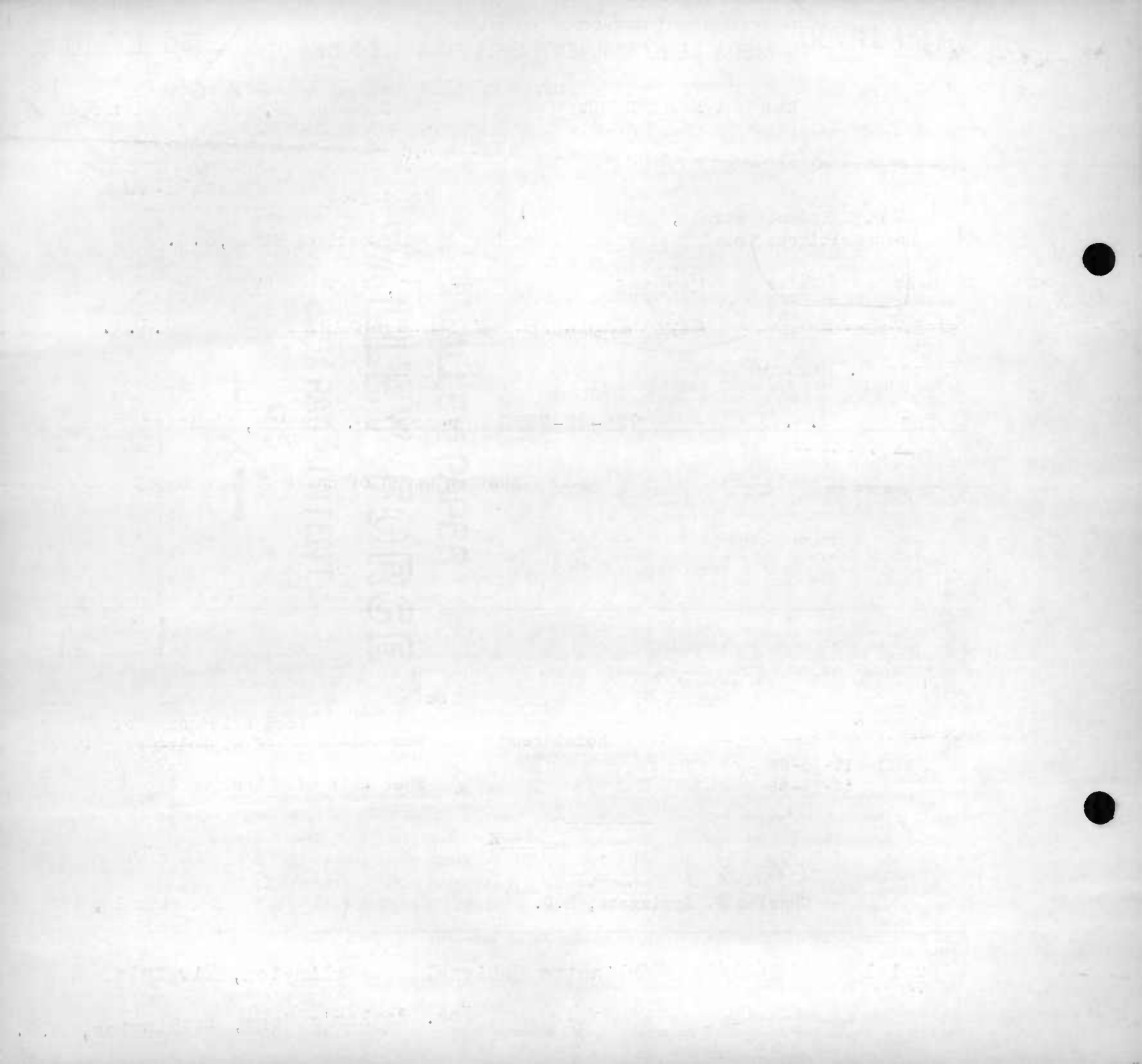
24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

DEC 21 1966

Jos. Gawler's Sons, Washington, D.C.



66 12741

BALTIMORE CITY HEALTH DEPARTMENT

66 12741

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Philip Apple (Philip A. Apple)

2. DATE AND HOUR PRONOUNCED DEAD

12/20/66 2:10 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

43 South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 21230

D. STREET ADDRESS (If rural, give location)

1708 Light St.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

Jan. 20, 1900

9. AGE (In years
last birthday)

66 (66)

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

net. laborer

10B. KIND OF BUSINESS OR INDUSTRY

Dept Sanitation

City of Balto.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

? Apple

14. MOTHER'S MAIDEN NAME

Anna (?)

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

220-01-2088

17. INFORMANT

Mrs. Eleanor M. McElroy

1915 Frames Rd Dundalk Balto Md 21222

18.

E 904.9 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)(A) Craniocerebral injury
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.Restriction of airway by blood clot due to bleeding at
tracheotomy site

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

?

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

?

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
12 17 66 ?

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

probably fell

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

EXAMINER'S

NAME (Type) Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/20/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Dec 24 1966

23C. NAME OF CEMETERY or CREMATORY

Loudon Park Cem

23D. LOCATION

(City, town, or county)

Balto Md

(State)

CURTIS E. EVANS

24A. DATE REC'D BY HEALTH DEPT.

DEC 21 1966

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

1400 S. Charles St Balto Md

21230

WALTER GORGE
VALLEY VIEW

[Handwritten signature]

CURTIS E EVANS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|---------------|---|--------------------------------|--|--|--|---|
| BIRTH NO. 66 12742 | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 66 12742 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Wallace P. Scott | | | | 2. DATE AND HOUR OF DEATH Dec. 18, 1966 4 A. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 603 Lennox Street | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 603 Lennox St., | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never Married | 8. DATE OF BIRTH Aug. 10, 1897 | 9. AGE (In years last birthday) 69 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter | | 11. BIRTHPLACE (State or foreign country) Md. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter | | 10B. KIND OF BUSINESS OR INDUSTRY Painting | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Daniel Scott | |
| 14. MOTHER'S MAIDEN NAME Annie Kelly | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Helena F. Scott 603 Lennox St., | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 1.50 X L 002.2 Disease or condition directly leading to death: Carcinoma of Esophagus ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pulmonary Tuberculosis - 17 yrs | | | | CAUSE OF DEATH (A) DUE TO Carcinoma of Esophagus (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 12 mos | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from January 5, 1957 to Decem 18, 1966, that (I) (we) last saw the deceased alive on Decem 7, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE M. W. Jacobson M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | |
| 23B. DATE SIGNED 12-19-66 | | 23C. PHYSICIAN'S NAME (Type) M. W. JACOBSON | | 23D. ADDRESS 6821 Reisterstown Road | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | |
| 24B. DATE 12-20-1966 | | 24C. NAME OF CEMETERY or CREMATORY New Cathedral | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. DEC 21 1966 | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR G. Howard Strong | | 25D. ADDRESS 3207 W. North Ave., | | VS 150-REV. 1/1/65 | |

Caroline / September 15, 1892

Belmont, Massachusetts - June 10, 1892
No

Received of Mr. W. W. Johnson
the sum of \$10.00

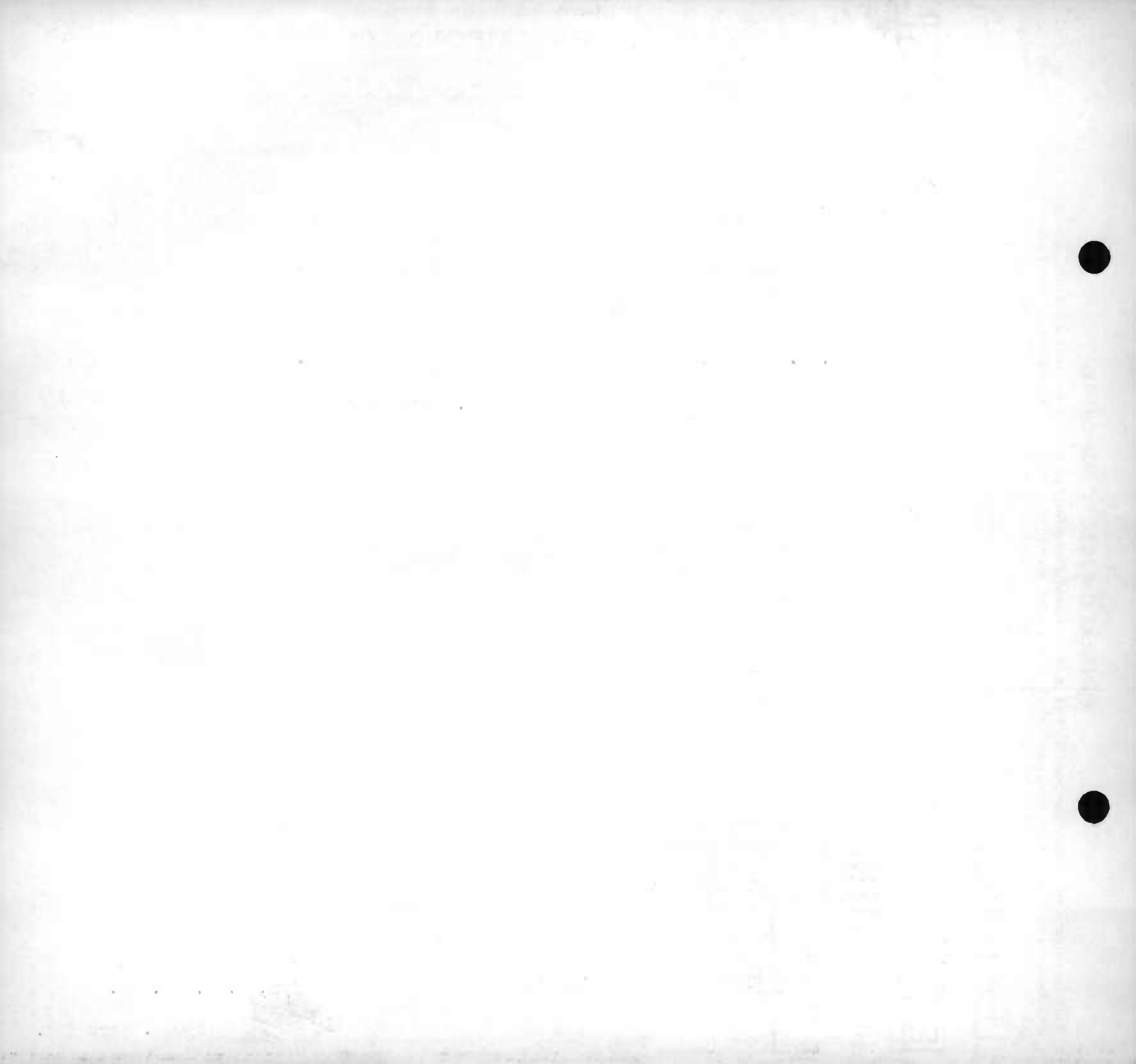
12-11-92

W. W. Johnson
12-11-92

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|--|-------------------------|---|--------------------------------------|---|--|
| BIRTH NO. 66 12743 | | CERTIFICATE OF DEATH | | 66 12743 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Sellman H. Forrester</i> | | 2. DATE AND HOUR OF DEATH <i>12-18-1966 6:37 P.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>43 South Baltimore General Hosp.</i> | | A. STATE <i>Maryland</i> B. COUNTY <i>24-02</i> | | C. CITY OR TOWN (If outside city limits, give RURAL and give township) <i>Baltimore #21230</i> | |
| (If not in hospital or institution, give street address or location) | | D. STREET ADDRESS (If rural, give location) <i>438 E. Grindall St.</i> | | | |
| 5. SEX <i>M.</i> | 6. RACE <i>White</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widower</i> | 8. DATE OF BIRTH <i>6-20-1886</i> | 9. AGE (In years last birthday) <i>80</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Silversmith</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Jewelry</i> | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U S A</i> | | 13. FATHER'S NAME <i>Wm. H. Forrester</i> | | 14. MOTHER'S MAIDEN NAME <i>Ella S. Patrick</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <i>Wm. Forrester 1200 Riverside Ave/</i> | |
| 18. <i>493X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Antecedent causes</i> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) <i>Pneumonia</i> DUE TO (B) _____ DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH <i>Approx 20 days</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>No.</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (at) (this hospital) attended the deceased from <i>12-9</i> 19 <i>66</i> to <i>12-18</i> 19 <i>66</i> , that (we) (we) last saw the deceased alive on <i>12-18</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>William F. Bruther</i> M.D. | | | | 23B. DATE SIGNED <i>12-19-66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>William F. Bruther</i> M.D. | | | | 23D. ADDRESS <i>1213 light St.</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12 21 1966</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Cedar Hill</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Brooklyn, A. A. Co. Md.</i> | | 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR <i>Mc Cully</i> | |
| 25C. FUNERAL DIRECTOR ADDRESS <i>130 E. Fort Ave.</i> | | 25D. NAME OF REGISTRAR <i>Sub E. Isley</i> | | 25E. FUNERAL DIRECTOR ADDRESS <i>130 E. Fort Ave.</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|---|------------------|--|---|--|--|
| BIRTH NO. | | 66 12744 | | 66 12744 | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) JOHNSON, MARY B | | | 2. DATE AND HOUR OF DEATH 12 18 66 10:50 A M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL | | | A. STATE MARYLAND | | |
| (If not in hospital or institution, give street address or location) | | | B. COUNTY a.g.c. | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | BALTIMORE 21225 52-00 | | |
| D. STREET ADDRESS (If rural, give location) | | | 183 MEADOW RD | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 1 3 98 | 9. AGE (In years last birthday) 68 | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HSWFE | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) W VA | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME SAMUEL | | | 14. MOTHER'S MAIDEN NAME ELIZABETH BAILEY | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ST AGNES HOSP RECORDS | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) DUE TO ASCVD CVA (B) DUE TO Uremia (C) | | INTERVAL BETWEEN ONSET AND DEATH |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. diabetes mellitus | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from 11 30 19 66 to 12 18 19 66, that (X) (we) last saw the deceased alive on 12 18 19 66 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE EM. WEISS, M.D. | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) EM. WEISS, M.D. | | | | 23D. ADDRESS WILKENS & CATON AVES ST. AGNES HOSPITAL BALTO., MD. 21229 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/21/66 | | 24C. NAME OF CEMETERY or CREMATORY Glen Haven | |
| 24D. LOCATION (City, town, or county) (State) Glen Burnie Md | | 25A. DATE REC'D BY HEALTH DEPT. | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR McCully F H 237 Patapsco Ave | | 25D. ADDRESS 21225 | |

1977-5479

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 66 12745 | |
|--|-----------|--|-------------------------|---|------------------------|--|-------------------------|
| BIRTH NO. 66 12745 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) John H. Rolfes | | 2. DATE AND HOUR OF DEATH Dec. 18, 1966 8:00 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | 37 Mercy Hospital | | A. STATE Maryland | | B. COUNTY Baltimore | |
| C. CITY OR TOWN (If outside city limits, write Rural and give township) | | Baltimore | | D. STREET ADDRESS (If rural, give location) | | 4943 Denmore Ave | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH 7-1-89 | 9. AGE (In years last birthday) 77 | 10. Under 1 Yr. Months | 11. Under 24 Hrs. Days | 12. Under 24 Hrs. Hours |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Timekeeper | | 10B. KIND OF BUSINESS OR INDUSTRY Hotel | | 11. BIRTHPLACE (State or foreign country) Maryland, Balto. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME John H. Rolfes | | | | 14. MOTHER'S MAIDEN NAME Clara ? | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 212-07-9342A | | 17. INFORMANT Hosp. Rec. | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.) | | | | (A) Cardiovascular Collapse | | Hours | |
| | | | | (B) Acute Myocardial Infarction | | 1-3 days | |
| | | | | (C) ASVD, ASCVD | | years | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | Hemorrhagic cystitis | | | |
| | | | | Mural Thrombus Left Ventricle of heart | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec. 17, 1966 to Dec 18 1966, that (I) (we) last saw the deceased alive on Dec 18, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Richard D. Shuger M.D. | | | | 23B. DATE SIGNED 12/18/66 | | | |
| 23C. PHYSICIAN'S NAME (Type) Richard D. Shuger | | | | 23D. ADDRESS Mercy Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/21/66 | | 24C. NAME of CEMETERY or CREMATORY Lorraine Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 21 1966 | | 25B. NAME OF REGISTRAR R. E. Feltner | | 25C. FUNERAL DIRECTOR Vernon Gammart | | ADDRESS 4611 Park Heights Ave. | |

100-77-1000

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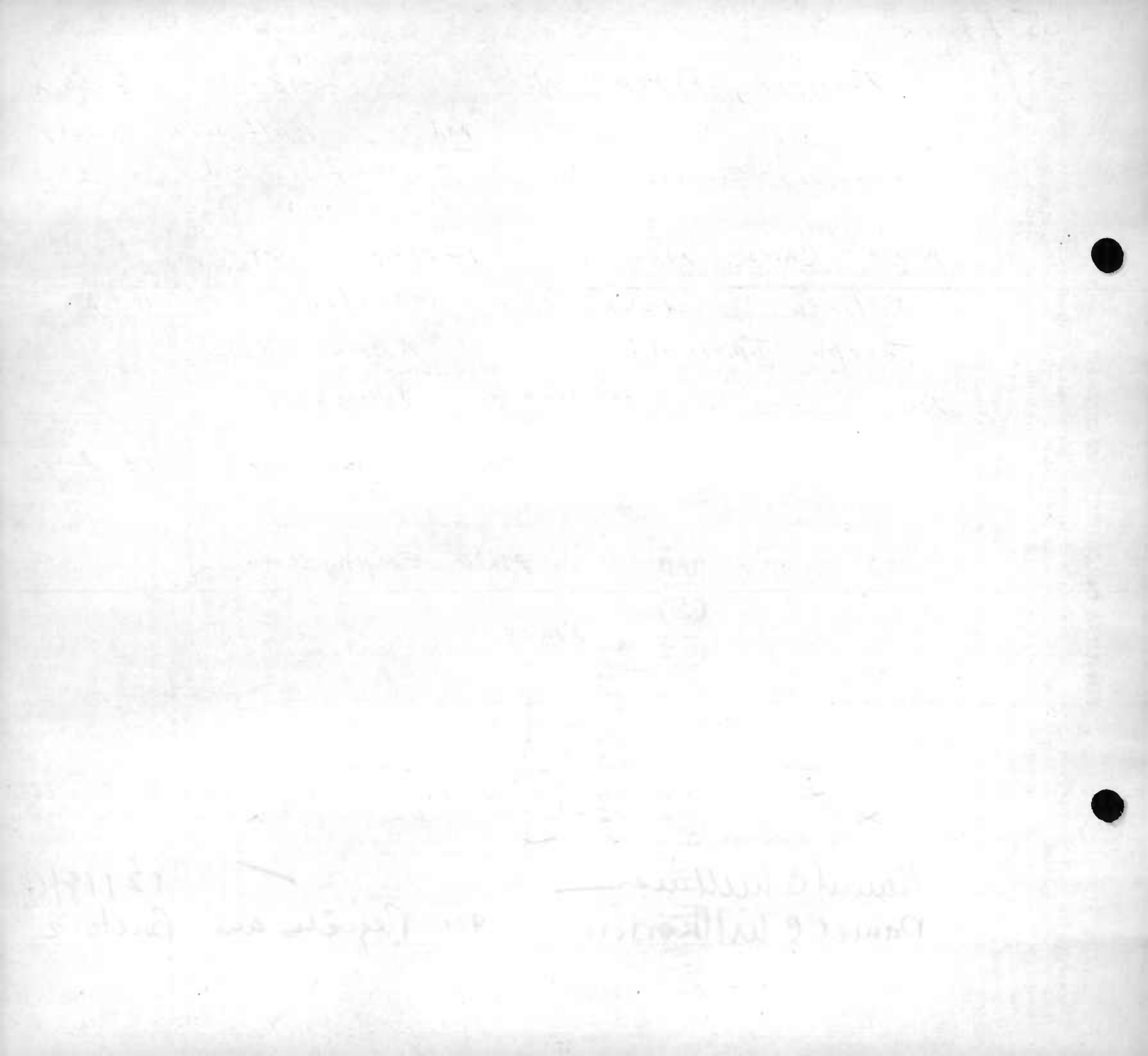
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100-77-1000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|--|---------------------------|--|---|--|---|
| 66 12746 | | CERTIFICATE OF DEATH | | 66 12746 | |
| 1. NAME OF DECEASED (Type or Print) TREMPER, Peter W. | | | 2. DATE AND HOUR OF DEATH 12-18-66 8:50 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND General Hosp. 48 | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Fullerton, Md. D. STREET ADDRESS (If rural, give location) 53-00 Cowenton Ave | | |
| 5. SEX MALE | 6. RACE CAUCAS. | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 1-19-85 | 9. AGE (in years last birthday) 81 | 10. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | | 10B. KIND OF BUSINESS OR INDUSTRY Ret. Farmer UNKNOWN | | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Joseph Tremper | | | 14. MOTHER'S MAIDEN NAME ANNA KAIB | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. 220-34-7058 | | |
| 17. INFORMANT DAUGHTER | | | ADDRESS | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 527.11 (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) BRONCHOPNEUMONIA | | | INTERVAL BETWEEN ONSET AND DEATH 14 days | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. MILD EMPHYSEMA | | | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None | | | | | |
| 21A. DATE OF OPERATION None | | 21B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21C. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) None | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from 12-4 19 66 to 12-18 19 66 , that (I) (X) lost saw the deceased alive on 12-17 19 66 and that in (my) (X) opinion death occurred on the date and hour and from the causes stated above. (I) (X) (did) (X) view the body after death. | | | | | |
| 23A. SIGNATURE Daniel C. Wilkerson M.D. | | | | 23B. DATE SIGNED 12/18/66 | |
| 23C. PHYSICIAN'S NAME (Type) Daniel C. Wilkerson M.D. | | | | 23D. ADDRESS 921 Regent Ave Baltimore | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-21-1966 | | 24C. NAME OF CEMETERY or CREMATORY St. Joseph's Cemetery | |
| 24D. LOCATION Baltimore | | 24E. (City, town, or county) | | 24F. (State) Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 21 1966 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Kassahn Paul/Hum | |
| 25D. ADDRESS 2401 Belvidere Rd | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 12747 | | | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 12747 | |
|--|---------------------|---|-------------------------------------|--|--|--|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) Alexander W. Oleske (Oleske) | | 2. DATE AND HOUR OF DEATH 12-16-66 3:00 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. 8. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland General Hospital | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21213 27-01 | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 2849 Pelham Ave. | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 12/18/94 | | 9. AGE (In years last birthday) 71 | If Under 1 Tr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist | | 10B. KIND OF BUSINESS OR INDUSTRY Gen. Electric | | 11. BIRTHPLACE (State or foreign country) Maryland Baltimore | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Albert Oleske | | | | 14. MOTHER'S MAIDEN NAME Valerie Roman | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 214-01-4855 | | 17. INFORMANT Katherine Oleske (nee Svec) | | ADDRESS same | |
| 18. 420.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Heart disease | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH 1 year | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) DUE TO | | | |
| | | | | (B) DUE TO | | | |
| | | | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. gangrene right leg due to thrombosis right iliac artery | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec. 14 1966 to Dec. 15 1966 , that (I) (we) lost saw the deceased alive on Dec. 16 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE W. Michael Gould | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/16/66 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/20/66 | | 24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 21 1966 | | 25B. NAME OF REGISTRAR Robert E. Fairman | | 25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. | | ADDRESS 3331 Brehms Lane | |

W. Michael R. Hall

Dec

16

Dec. 14

Dec

Dec

Dec

12/16/60

X

64-01-4832

Katherine Clark

Answer

Albert Clark

Gen Electr.

M. W.

Arrived

12/16/60

Maryland

U. S. A.

Maryland General Hospital

52nd Polk Ave
Baltimore 21112

Md

Alexander W. Clark

12-16-60

2000

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12748

BIRTH NO. 66 12748

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JAMES G. HUDSON

2. DATE AND HOUR PRONOUNCED DEAD

December 16, 1966 3:25 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

35 Church Home and Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 6-02

D. STREET ADDRESS (If rural, give location)

101 N. Glover Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

Feb. 22, 1915

9. AGE (in years
last birthday)

51

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Tavern

10B. KIND OF BUSINESS OR INDUSTRY

Own Business

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Milton Hudson

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown; if yes, give war or dates of service)16. SOCIAL
SECURITY NO.

220-01-5813

17. INFORMANT

ADDRESS

Mary Quade Hudson, wife, above

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/17/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/19/66

23C. NAME of CEMETERY or CREMATORY

Oak Lawn Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

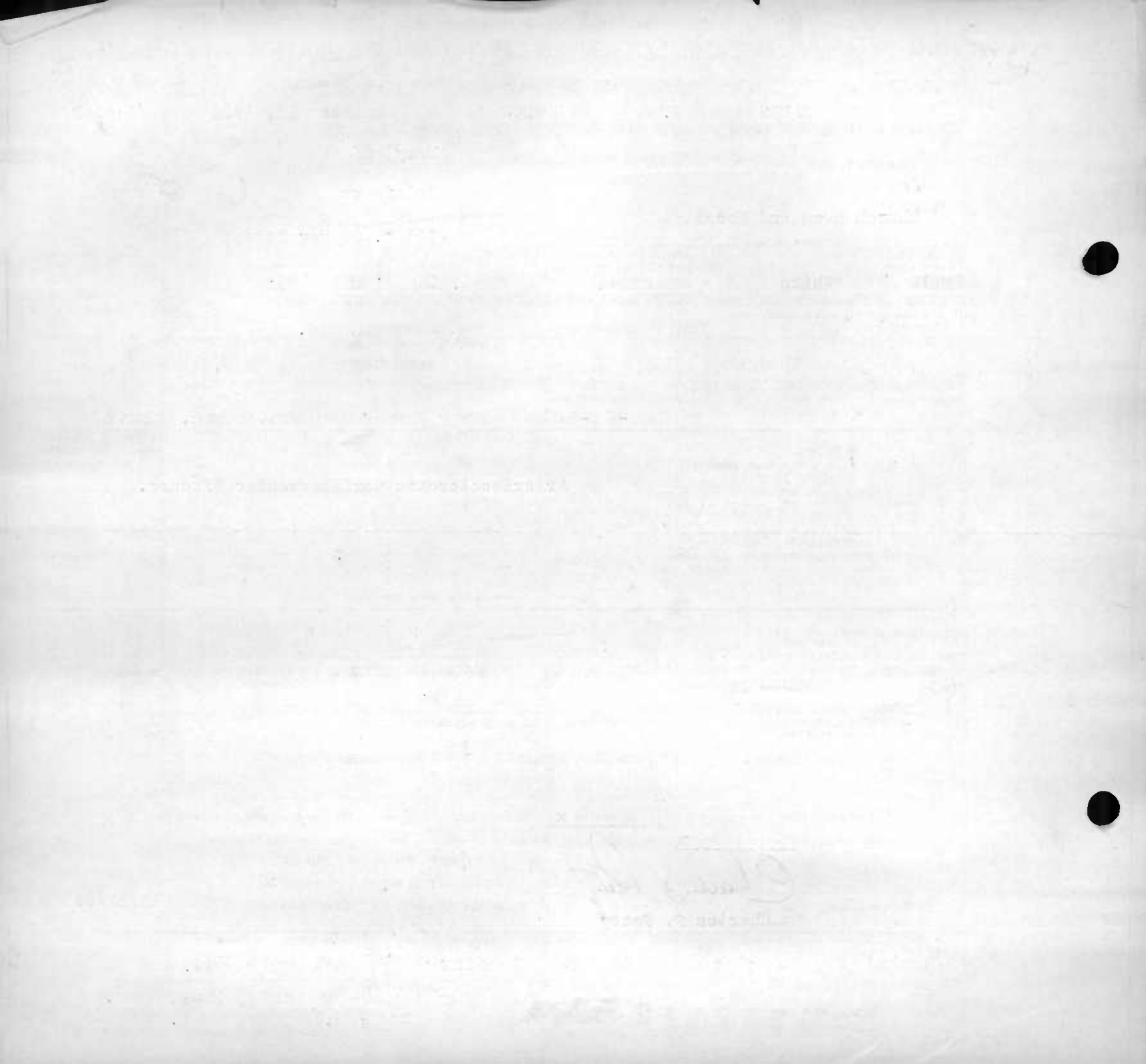
ADDRESS

DEC 21 1966

R. E. Farley

Schimunek Funeral Home, Inc.

2601 E. Madison St.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 12749</u> |
|--|---|---|--|--|
| BIRTH NO. <u>66 12749</u> | | CERTIFICATE OF DEATH | | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH <u>12/20/66 4:15 AM</u> | | |
| 1. NAME OF DECEASED (Type or Print) <u>ROBINSON BESSIE M.</u> | | M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>46 LUTHERAN HOSPITAL OF MARYLAND</u> | | A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>15-06</u> D. STREET ADDRESS (If rural, give location) <u>3610 HERBERT ST.</u> | | |
| 5. SEX <u>FEMALE</u> | 6. RACE <u>NEGRO</u> | 7. MARRIED NEVER MARRIED <u>(WIDOWED)</u> DIVORCED (specify) | 8. DATE OF BIRTH <u>4/23/04</u> | 9. AGE (In years last birthday) <u>62</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) <u>N.C.</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>John R. Carter</u> | | 14. MOTHER'S MAIDEN NAME | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS <u>Ruth Diggs 2703 Lawina Rd.</u> | |
| 18. <u>5810 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) <u>Post Necrotic Cirrhosis</u> (B) DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | <u>Dehydration Cachexia Anemia</u> | | |
| 19A. DATE OF OPERATION <u>2</u> | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Dec 4</u> 19 <u>66</u> to <u>Dec 20</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec 20</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE <u>Young Kil Kim</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>12/20/66</u> |
| 23C. PHYSICIAN'S NAME (Type) <u>YOUNG KIL KIM</u> | | M.D. <u>LUTHERAN HOSPITAL OF MARYLAND</u> | | |
| 24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u> | 24B. DATE <u>12-23-66</u> | 24C. NAME OF CEMETERY OR CREMATORY <u>Balto. Natl. Cem.</u> | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 21 1966</u> | 25B. NAME OF REGISTRAR <u>John E. Johnson</u> | 25C. FUNERAL DIRECTOR ADDRESS <u>George A. Kilmer 1348 N. Calhoun St</u> | | |

HERNANDEZ
LUNERAN HOSPITAL OF MARIANA
4/2/61

Post Necrotic Cystitis

Calabria
Siphon

Dec 20
Dec 21

Young Kil Kim
LUNERAN HOSPITAL OF MARIANA
12/20/61

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--|--|--|---|--|
| BIRTH NO. 66 12750 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12750 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Ella Hill | | | 2. DATE AND HOUR OF DEATH 12-17-66 M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 2410 Stockton Street | | | A. STATE Md. B. COUNTY Balto. | | |
| 5. SEX Female | | | 6. RACE Negroid | | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | | | 8. DATE OF BIRTH 12-20-24 | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 9. AGE (In years last birthday) 42 | | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country) South Carolina | | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 13. FATHER'S NAME | | |
| 14. MOTHER'S MAIDEN NAME Irene Garrett | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS Herbert Hill 2410 Stockton St. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) Cerebral vascular accident (B) Hypertensive C.V.D. (C) | | |
| INTERVAL BETWEEN ONSET AND DEATH Few hours | | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 20A. AUTOPSY? (Yes or No) No | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from 5-20-1965 to 12-17-1966, that (I) (we) last saw the deceased alive on 12-13-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE C.R. Campbell | | | 23B. DATE SIGNED 12-20-66 | | |
| 23C. PHYSICIAN'S NAME (Type) C.R. Campbell | | | 23D. ADDRESS 1618 W. North Ave. Baltimore, Md. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-21-66 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery | |
| 24D. LOCATION Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. DEC 21 1966 | | | |
| 25B. NAME OF REGISTRAR R. E. F. F. | | 25C. FUNERAL DIRECTOR George G. Kelson | | | |
| 25D. ADDRESS 1348 N. Calhoun St. | | | | | |

Central American Government

Hypertensive C.V.D.

No

2-20-62 12-17

12-13

C.R. Campbell
C.R. Campbell

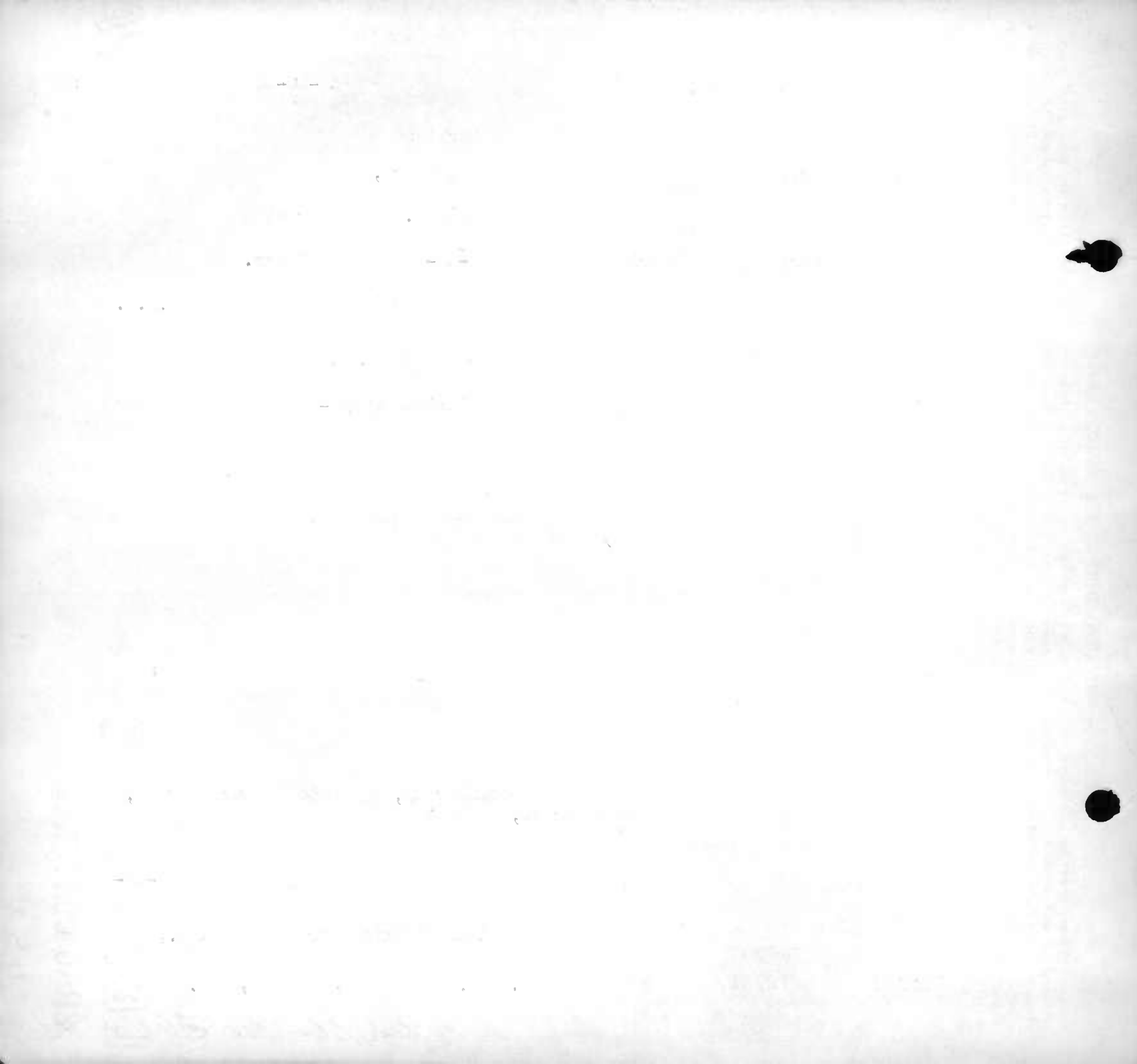
1-2-62

1010 W. North Ave. Farmington

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12751 | |
|--|------------------------------|---|---|--|---|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 66 12751 | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) Ellen Handy | | | 2. DATE AND HOUR OF DEATH 12-20-66 8:50 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident (If not in hospital or institution, give street address or location) | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore, C. CITY OR TOWN (If outside city limits, write RURAL and give township) 15-02 D. STREET ADDRESS (If rural, give location) 1502 N. Mount Street | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 9-17-12 | 9. AGE (In years last birthday) 54 yrs. | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) West Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME John Lee | | | 14. MOTHER'S MAIDEN NAME Hazel Trust | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | 17. INFORMANT William Handy - husband | | ADDRESS SAME |
| 18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) Cerebral Hemorrhage DUE TO (B) Essential Hypertension DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH one wk two years |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from December 13, 1966 to December 20, 1966 , that (I) (we) lost saw the deceased alive on December 20, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Roland T. Smoot | | | | 23B. DATE SIGNED 12-20-66 | |
| 23C. PHYSICIAN'S NAME (Type) ROLAND T. SMOOT | | | | 23D. ADDRESS M.D. 1514 Division Street Balto., Maryland | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 12/24/66 | 24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Pk. | | 24D. LOCATION (City, town, or county) (State) Arbutus, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 21 1966 | | 25B. NAME OF REGISTRAR Robert E. Feltman | | 25C. FUNERAL DIRECTOR George A. Feltman 1348 N. Calhoun St | |



| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | Registered No. 66 12752 | |
|---|---------|--|------------------|---|---|--|--|
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR PRONOUNCED DEAD | | | |
| | | WILLIAM (HARRIS) HARRISON | | December 16, 1966 | | 10:10 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE | | B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | Maryland | | C. CITY OR TOWN (If outside corporate limits, give RURAL and give township) | | Baltimore | |
| 38 University Hospital | | D. STREET ADDRESS (If rural, give location) | | 603 Pierce Street | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | | |
| Male | Negro | Separated | 6-15-00 | 66 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Laborer | | | | Bluffton, Ga. | | U.S.A. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | | | |
| Eugene Harrison | | Mary Mongle | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| no | | 214-18-6101 | | Mrs. Mabel Jenkins 1002 E. Hoffman St. | | | |
| 18. CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | (A) Multiple Traumatic Injuries. DUE TO | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) DUE TO | | | | | |
| | | (C) DUE TO | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 2 | | | | Yes | | Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | Street | | Mulberry St., E. of Fremont St. | | 17-03 | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| (Month) (Day) (Year) (Hour) | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | Pedestrian struck by auto. | | | |
| 12 16 '66 P | | | | | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE | | CHIEF MEDICAL EXAMINER | | DATE SIGNED | | | |
| EXAMINER'S NAME (Type) | | M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 12/17/66 | | | |
| Charles S. Petty | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | | 23C. NAME of CEMETERY or CREMATORY | | 23D. LOCATION (City, town, or county) (State) | |
| Burial | | 12-22-66 | | Mt. Calvary Cemetery | | A.A.Co., Maryland | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | | 24C. FUNERAL DIRECTOR | | ADDRESS | |
| | | | | Marshall W. Jones, Jr. | | 1735 Harford Ave. | |

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48-32-29 IB

A-35266 12753

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

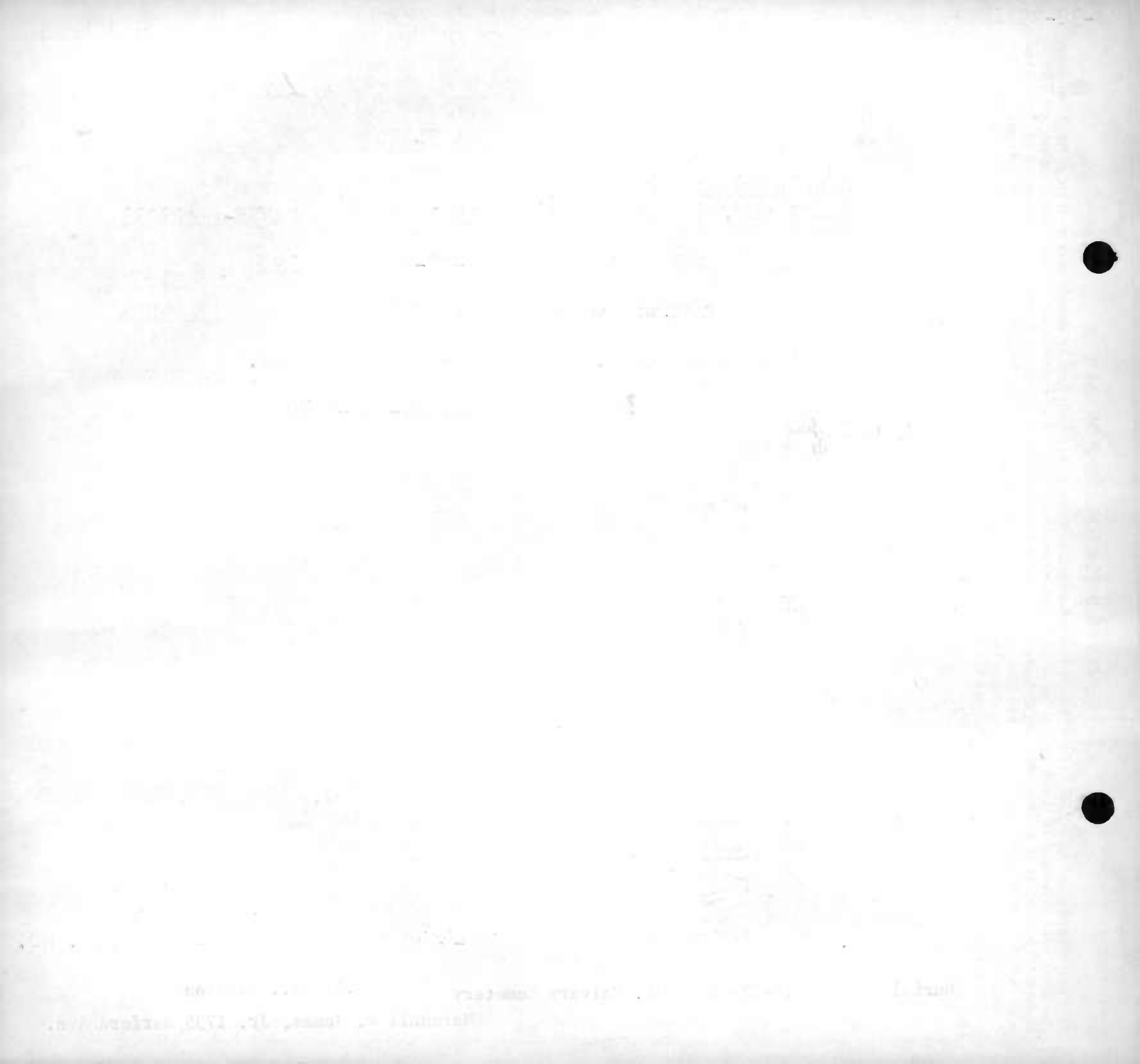
Registered No.

66 12753

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

| | | | |
|---|-------------------------|---|--|
| BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <i>Mansfield Adams</i> | | 2. DATE AND HOUR OF DEATH <i>12/19/66 2:30 A.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224</i> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY C. CITY OR TOWN (If outside city limits, with RURAL and give township) <i>BALTIMORE</i> D. STREET ADDRESS (If rural, give location) <i>1301 LINWOOD AVENUE- #21213</i> | |
| 5. SEX <i>MALE</i> | 6. RACE <i>NEGRO</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>NEVER MARRIED</i> | 8. DATE OF BIRTH <i>9-27-27</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>LABOR</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>CARLING BLACK LABLE</i> | 9. AGE (In years last birthday) <i>39</i> |
| 11. BIRTHPLACE (State or foreign country) <i>VIRGINIA</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>MANSFIELD ADAMS (DEC.)</i> | | 14. MOTHER'S MAIDEN NAME <i>MARTHA EXTON (DEC.)</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i> | | 16. SOCIAL SECURITY NO. <i>?</i> | |
| 17. INFORMANT <i>#21224</i> | | ADDRESS <i>RECORDS-BCH-4940 EASTERN AVENUE</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>00211</i> | | CAUSE OF DEATH (A) <i>Hemoptysis + Aspiration</i> DUE TO (B) <i>Tuberculosis</i> DUE TO (C) _____ | |
| INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>8 yrs</i> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) <i>NO</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (he) (this hospital) attended the deceased from <i>12-17</i> <i>1966</i> to <i>12-19</i> <i>1966</i> , that (he) (we) last saw the deceased alive on <i>12-19</i> <i>1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <i>Richard L Bishop</i> | | 23B. DATE SIGNED <i>12-19-66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>DR. RICHARD BISHOP</i> | | 23D. ADDRESS <i>BCH-4940 EASTERN AVENUE-BALTIMORE, MD.</i> | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12-22-66</i> | |
| 24C. NAME OF CEMETERY or CREMATORY <i>Mt. Calvary Cemetery</i> | | 24D. LOCATION (City, town, or county) (State) <i>A.A. Co., Maryland</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 21 1966</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Faldy</i> | |
| 25C. FUNERAL DIRECTOR <i>Marshall W. Jones, Jr.</i> | | ADDRESS <i>1735 Harford Ave.</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12754 | |
|--|---------------------|--|---|--|---|
| BIRTH NO. 66 12754 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) ELEANOR JOHNSON | | | DECEMBER 16, 1966 M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 43 SOUTH BALTIMORE GENERAL HOSPITAL | | | A. STATE MD B. COUNTY BALTIMORE | | |
| (If not in hospital or institution, give street address or location) | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | |
| | | | D. STREET ADDRESS (If rural, give location) 804 Bethune Road | | |
| 5. SEX F | 6. RACE C | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) ? | 8. DATE OF BIRTH 6/12/10 | 9. AGE (In years last birthday) 56 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Baltimore Md | | 12. CITIZEN OF WHAT COUNTRY? U S A |
| 13. FATHER'S NAME ? | | | 14. MOTHER'S MAIDEN NAME ? | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 212-26-4572 | 17. INFORMANT ADDRESS M.s Audrey Bolden 804 Bethune Rd | | |
| 18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) DUE TO Cerebro-Vascular Accident (B) DUE TO Pulmonary Edema (C) DUE TO Diabetes Mellitus | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Oct 13, 1966 to 19 , that (I) (we) last saw the deceased alive on Oct 13, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Jerry C. Luck | | | | 23B. DATE SIGNED Dec 17, 1966 | |
| 23C. PHYSICIAN'S NAME (Type) Jerry C. Luck | | | | 23D. ADDRESS 427 Swale Rd. BALTO. 25th. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/20/66 | | 24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cemetery | |
| 24D. LOCATION A A County Md | | 25A. DATE REC'D BY HEALTH DEPT. DEC 21 1966 | | | |
| 25B. NAME OF REGISTRAR Adolphus Halstead | | 25C. FUNERAL DIRECTOR ADDRESS 1206 W North Ave | | | |

SECRET
TELETYPE

Page 2

Mc Carthy County

22/20/66

1/2/67

Additional Material 1206 V 1000

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

66 12755

66 12755

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

EDNA

MAXWELL

2. DATE AND HOUR PRONOUNCED DEAD

December 17, 1966

9:30 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1214 W. North Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3019 Ridgewood Avenue

5. SEX

Female

6. RACE

negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

1/15/42

9. AGE (In years
last birthday)

24

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Nurses Aid

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Eddie Maxwell, Sr

14. MOTHER'S MAIDEN NAME

Harriet Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Miss Maggie Maxwell 4940 Eastern Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

(A) Bronchopneumonia, Bilateral, Extensive.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/18/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/21/66

23C. NAME OF CEMETERY or CREMATORY

Mt Calvary Cemetery

23D. LOCATION

(City, town, or county)

(State)

A A County Md

24A. DATE REC'D BY HEALTH DEPT.

DEC 21 1966

24B. NAME OF REGISTRAR

Robert E. J. J. J.

24C. FUNERAL DIRECTOR

Adolphus Halstead

ADDRESS

1206 W North Ave

1/2/72

Single

North Canyon

North Canyon

North Canyon

North Canyon

North Canyon

North Canyon

North Canyon

North Canyon

North Canyon

North Canyon

North Canyon

North Canyon

North Canyon

North Canyon

North Canyon

North Canyon

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | Registered No. 66 12756 | |
|---|--|--|--|--|--|
| 66 12756 | | | | | |
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) MARY COLEMAN | |
| 2. DATE AND HOUR OF DEATH DECEMBER 18, 1966 11:15 A.M. | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 44 Union Memorial Hospital | | | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY | | 5. SEX FEMALE | | 6. RACE NEGRO | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | | 8. DATE OF BIRTH 09-?-79 | |
| D. STREET ADDRESS (If rural, give location) 2217 Disguith St. | | 9. AGE (In years last birthday) 87 | | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) South Carolina | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME JAMES W. Wilson | | 14. MOTHER'S MAIDEN NAME MARY UNKNOWN | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT LOWELLA LEE (daughter) | |
| 18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebrovascular Accident INTERVAL BETWEEN ONSET AND DEATH 23 days | | 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hypertensive Arteriosclerotic Cardiovascular Disease 20 years | | 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from DECEMBER 14, 1966 to DECEMBER 18, 1966 , that (I) (we) last saw the deceased alive on DEC. 18, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE James W. Carty, Jr. | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/18/66 | |
| 23C. PHYSICIAN'S NAME (Type) JAMES W. CARTY, JR. | | 23D. ADDRESS THE UNION MEMORIAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/23/66 | | 24C. NAME of CEMETERY or CREMATORY Lynchburg | |
| 24D. LOCATION (City, town, or county) (State) South Carolina | | 25A. DATE REC'D BY HEALTH DEPT. | | | |
| 25B. NAME OF REGISTRAR Adolphus Halstead | | 25C. FUNERAL DIRECTOR ADDRESS 1206 W North Ave | | | |

1917

1917

WARRAND

BEATTING

21.7 August 24

09.7.79 81

2nd Quarter

May Unknown

House No. 101 (101) 101

Subsidiary Building

Subsidiary Building

Union Memorial Hospital

Female Dept. W. Jones

House No.

James Wilson

No.

James W. Carter

AMES W. CARTER

12/23/00

12/23/00

12/23/00

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|---|--------------------------------------|---|---|
| BIRTH NO. 66 12757 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12757 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>ROCKEL Christopher</i> | | 2. DATE AND HOUR OF DEATH <i>Dec. 20, 1966 6:20 A.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <i>MD</i> B. COUNTY | | 5. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>35 Church Home & Hospital</i> | | C. STREET ADDRESS (If rural, give location) <i>2007 Sparks Ct.</i> | | D. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | |
| 5. SEX <i>M</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH <i>Dec. 2, 1888</i> | 9. AGE (In years lost birthday) <i>78</i> | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Foundry</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | |
| 13. FATHER'S NAME <i>Charles Rockel</i> | | 14. MOTHER'S MAIDEN NAME <i>Mary Dice</i> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes WW I</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <i>Cus Rockel 1 N. Decker St.</i> | |
| 18. <i>199.2 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) <i>Conjunctive Failure</i> DUE TO (B) <i>Arterio sclerosis Heart Dis.</i> DUE TO (C) <i>Carcinomatous</i> | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>Yes</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Dec. 18</i> 19 <i>66</i> to <i>Dec. 20</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>Dec. 20</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Henry</i> M.D. | | 23B. DATE SIGNED <i>12-30-66</i> | | 23C. PHYSICIAN'S NAME (Type) <i>Winita Searey</i> M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12-24-1966</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Woodlawn</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 21 1966</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Taylor</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>Lilly & Zeiler Inc. 1901-07 Eastern Ave.</i> | |
| 24D. LOCATION (City, town, or county) <i>Baltimore County, Maryland</i> | | 24E. STATE (State) | | | |

about 1000 ft. high
2000 ft. high

W
Thursday
Charles Foster

Thursday
May 2nd
C. Foster

Collected from
C. Foster

about 2000 ft.
about 2000 ft.
about 2000 ft.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such approval must be obtained before the remains are embalmed or final disposition is made.

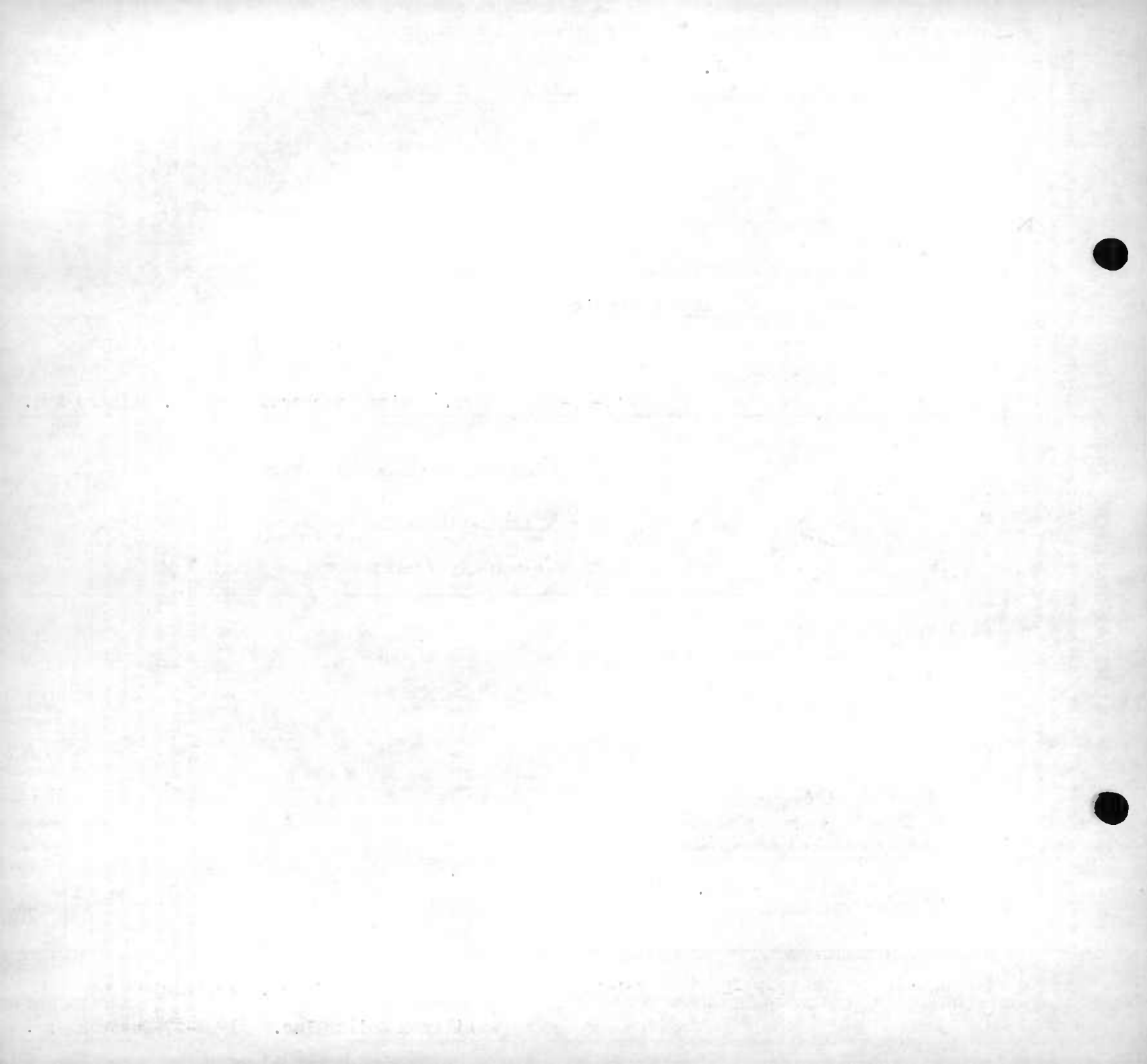
| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. 66 12758 | | CERTIFICATE OF DEATH | | Registered No. 66 12758 | |
|---|-------------------------|--|---|--|--|---|-----------------------------|----------------------------------|--|
| 1. NAME OF DECEASED (Type or Print) DOMINIC CANAVELLI (Cannawalle) | | | | 2. DATE AND HOUR OF DEATH December 19, 1966 3 A. M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 6201 Old Harford Road | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 6201 Old Harford Road | | | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widower | 8. DATE OF BIRTH June 23, 1880 | 9. AGE (In years last birthday) 86 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | | 10B. KIND OF BUSINESS OR INDUSTRY Laborer | | | 11. BIRTHPLACE (State or foreign country) Sicily | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Not Known | | | 14. MOTHER'S MAIDEN NAME Sadie | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 218-10-4183 | | 17. INFORMANT ADDRESS Mrs. Sadie DeAngelis 6201 Old Harford Road | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease | | | | (A) DUE TO | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO | | | | | |
| (C) DUE TO | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1966 to Dec 19 19 66 , that (I) was lost saw the deceased alive on Dec 16 19 66 and that in my our opinion death occurred on the date and hour and from the causes stated above. (I) was (did) did not view the body after death. | | | | | | | | | |
| 23A. SIGNATURE James F. White | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED Dec 19, 1966 | | | |
| 23C. PHYSICIAN'S NAME (Type) James F. White | | | | 23D. ADDRESS 5214 Harford Road, Baltimore, MD 21214 | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-22-1966 | | 24C. NAME of CEMETERY or CREMATORY Holy Redeemer | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 21 1966 | | 25B. NAME OF REGISTRAR A. E. F. J. J. J. | | 25C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901-07 Eastern Ave. | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--------------------------------|---|--|--|---|
| BIRTH NO. 66 12759 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 12759 | |
| 1. NAME OF DECEASED (Type or Print) CHARLES J. EVERHARDT | | | 2. DATE AND HOUR OF DEATH 12-19-66 11:35 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY BALTO | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 37 MERCY HOSPITAL | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO | | |
| | | | D. STREET ADDRESS (If rural, give location) 623 S. BELNORD AVE | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 1-8-90 | 9. AGE (In years last birthday) 76 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | 10B. KIND OF BUSINESS OR INDUSTRY Auto Mechanic | 11. BIRTHPLACE (State or foreign country) BALTO | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME CHARLES EVERHARDT | | | 14. MOTHER'S MAIDEN NAME CATHERINE KAHL | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 7 | | 16. SOCIAL SECURITY NO. 215-03-3984 | 17. INFORMANT ADDRESS Mrs. Louise Everhardt 623 S. Belnord Ave. | | |
| 18. 331X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) BILATERAL BASILAR PNEUMONIA DUE TO (B) FRONTAL LOBE INTRACEREBRAL HEMATOMA DUE TO (C) GENERALIZED ARTERIOCLEROSIS | | | INTERVAL BETWEEN ONSET AND DEATH 4 days 4 days Y. | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 12-16-66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED INTRACEREBRAL HEMATOMA | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 12-15 19 66 to 12-19 19 66 , that (1) (we) last saw the deceased alive on 12-19 19 66 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE J. M. Banash M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED 12-20-66 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 12-23-1966 | 24C. NAME OF CEMETERY or CREMATORY Trinity | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 21 1966 | | 25B. NAME OF REGISTRAR Robert E. Talley | 25C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901-07 Eastern Ave. | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|---|--|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. <u>66 12760</u> | |
| BIRTH NO. <u>66 12760</u> | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED <u>TAYLOR, MR. PRESTON (Dan)</u> | |
| 2. DATE AND HOUR OF DEATH <u>12-13-66</u> <u>10:28 AM</u> M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Bon Secours Hospital</u> <u>34</u> | | A. STATE <u>md</u> B. COUNTY | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Balto</u> | |
| | | D. STREET ADDRESS (If rural, give location) <u>2553 W. Fairmount Ave.</u> | |
| 5. SEX <u>M</u> | 6. RACE <u>Negro</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Single</u> | 8. DATE OF BIRTH <u>12-25-95</u> |
| | | | 9. AGE (In years last birthday) <u>70</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labourer</u> | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) <u>Florence, S.C.</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>?</u> | 14. MOTHER'S MAIDEN NAME <u>?</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes or no or unknown) (If yes, give war or dates of service) <u>No</u> | 16. SOCIAL SECURITY NO. <u>215-01-78244</u> | 17. INDEMNITY ADDRESS <u>Phyllis Butler, 3644 Edmonson Ave</u> | |
| 18. <u>443X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Hypertensive cardiovascular disease</u> | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION <u>0</u> | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED While At <input type="checkbox"/> Net While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Dec. 11, 1966</u> to <u>Dec. 12, 1966</u> , that (I) (we) last saw the deceased alive on <u>Dec. 12, 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <u>DAE HUN KIM</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | 23B. DATE SIGNED |
| 23C. PHYSICIAN'S NAME (Type) <u>DAE HUN KIM</u> | | 23D. ADDRESS <u>Bon Secours Hospital</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | 24B. DATE <u>12-16-66</u> | 24C. NAME of CEMETERY or CREMATORY <u>Mt Auburn</u> | 24D. LOCATION (City, town, or county) (State) <u>Baltimore md</u> |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 21 1966</u> | 25B. NAME OF REGISTRAR <u>R. E. Farley</u> | 25C. FUNERAL DIRECTOR ADDRESS <u>Purnell B. Oden - Balto. md</u> | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 12761 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12761 | |
|--|-------------------------|--|--|---|--|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) BLAKE, ARTHUR J. | | | | 2. DATE AND HOUR OF DEATH 12/17/66 1:00 AM | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 46 LUTHERAN HOSPITAL OF MARYLAND | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 16-07 | | | |
| D. STREET ADDRESS (If rural, give location) 2915 ELLICOTT DR. | | | | | | | |
| 5. SEX MALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH 12/24/91 | 9. AGE (In years lost birthday) 74 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME George Blake | | | | 14. MOTHER'S MAIDEN NAME Agnes Penn | | | |
| 15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes U.S. #1 | | | | 16. SOCIAL SECURITY NO. 217-01-5706 | | 17. INFORMANT Mrs M^cGowen 2915 Ellcott Dr | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 002.1 Pulm. Tuberculosis | | | | CAUSE OF DEATH (A) DUE TO Hypoglycemic episodes (B) DUE TO of unknown etiology (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED White At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec 14 19 66 to Dec 17 19 66 . that (I) (we) last saw the deceased alive on Dec 17 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Young Kil Kim M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/17/66 | |
| 23C. PHYSICIAN'S NAME (Type) YOUNG KIL KIM M.D. | | | | 23D. ADDRESS LUTHERAN HOSPITAL OF MARYLAND | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-21-66 | | 24C. NAME OF CEMETERY or CREMATORY Balto National Cem. Balto | | 24D. LOCATION (City, town, or county) (State) MD | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR Robert E. Farley | | 25C. FUNERAL DIRECTOR Rayner Sanders | | ADDRESS 217 E. Preston St | |

1
M-600

66 12762

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 12762

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JERRY MOORE

2. DATE AND HOUR PRONOUNCED DEAD

December 19, 1966 2:20 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33 99 Church Home Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1436 E. Baltimore Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

8-17-1944

9. AGE (In years
last birthday)

22

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Labor

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto Md

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Jeffer Moore

14. MOTHER'S MAIDEN NAME

Willie Mae Gragg

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown (If yes, give war or dates of service))

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Willie Mae Gragg 315 S. Bittel St

18.

E 981X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Gunshot wound of back
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

3 N. Caroline Street

21D TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

12-19-66

?

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot by wife

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL
SIGNATURE

Charles S. Springate

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

December 19, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12-22-66

23C. NAME of CEMETERY or CREMATORY

Int Calvary Cmt

23D. LOCATION (City, town, or county) (State)

Brooklyn Md

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

THE POWER

BIRTH NO. 66 12763 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12763

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Matthew Gardner

2. DATE AND HOUR PRONOUNCED DEAD

12/20/66

3:44 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

531 N. Gilmer St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

3-15-1916

9. AGE (In years
last birthday)

50

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF
WHAT COUNTRY

USA

13. FATHER'S NAME

Oscar Gardner

14. MOTHER'S MAIDEN NAME

Cora Goode

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

Michael Gardner

ADDRESS

Same

18.

443 X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)Hypertensive cardiovascular disease
(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner H. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/20/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12-23-66

23C. NAME of CEMETERY or CREMATORY

Olivet Cent

23D. LOCATION

(City, town, or county)

Olivet

(State)

Md

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

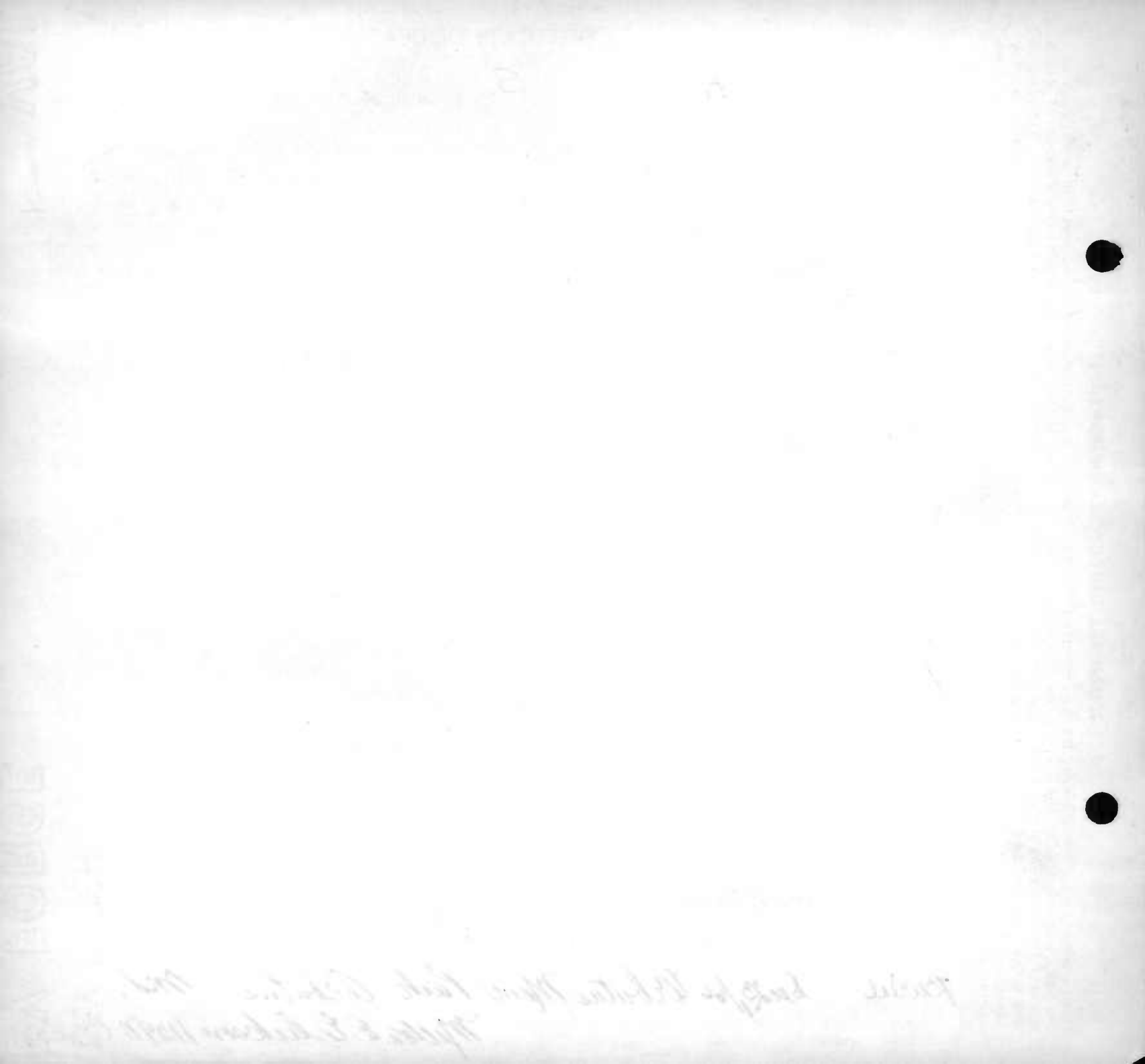
Choy Wilson or Brantley

VALLEY RECORD
PUBLISHED WEEKLY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|------------------|--|----------------------------------|--|--|
| BIRTH NO. 66 12764 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12764 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) BROWN, EUGENE S. | | 2. DATE AND HOUR OF DEATH 6:50 AM 12/20/66 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | M. | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS | | A. STATE M.D. B. COUNTY BALTIMORE | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21218 | |
| 33 | | D. STREET ADDRESS (If rural, give location) 315 E 24th St | | 12-04 | |
| 5. SEX M | 6. RACE C | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) M | B. DATE OF BIRTH 08/25/02 | 9. AGE (In years last birthday) 64 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Freight Handler | | 10B. KIND OF BUSINESS OR INDUSTRY TRANSPORTATION | | 11. BIRTHPLACE (State or foreign country) COLUMBIA S.C. | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME James | | 14. MOTHER'S MAIDEN NAME Eleanor Jenkins | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNK. | | 16. SOCIAL SECURITY NO. 016-21-96 | | 17. INFORMANT pt. ADDRESS | |
| 18. 157X I | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) Wide Spread metastatic | | 6 wks | |
| ANTECEDENT CAUSES | | (B) ca (Pancreas?) | | 1 yr | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 12/19/66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Exploratory lap | | 20A. AUTOPSY? (Yes or No) NO | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from 12/14 19 66 to 12/20 19 66 , that (I) (we) last saw the deceased alive on 12/20 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Melvin H. Epstein | | M.D. Attending <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/20/66 | |
| 23C. PHYSICIAN'S NAME (Type) MELVIN H. EPSTEIN | | M.D. JOHNS HOPKINS | | 23D. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Dec 23/66 | | 24C. NAME OF CEMETERY or CREMATORY Orbitus Mem Park | |
| 24D. LOCATION (City, town, or county) Orbitus Md. | | 24E. STATE Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 21 1966 | | 25B. NAME OF REGISTRAR Robert E. Jackson | | 25C. FUNERAL DIRECTOR William E. E. Jackson | |
| 25D. ADDRESS 11297 Carroll St | | | | | |



FUNERAL DIRECTOR: IMPORTANT

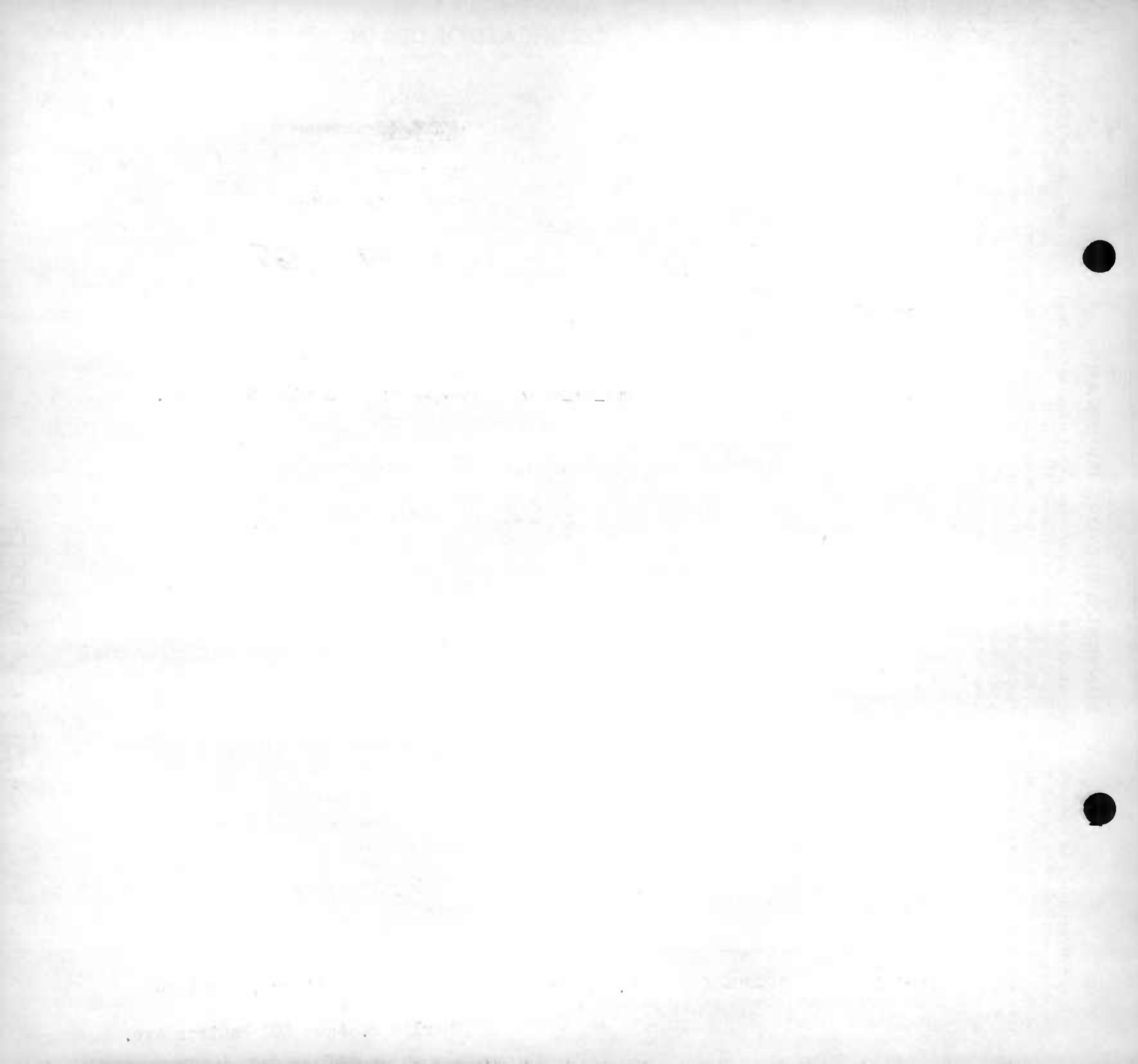
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|-------------------------|--|---|--|--|---|--|-------------------------------------|--|
| W-23 66 12765 | | | | | CERTIFICATE OF DEATH | | Registered No. 66 12765 | | |
| 1. NAME OF DECEASED (Type or Print) West, Rosina Bailey | | | | | 2. DATE AND HOUR OF DEATH 12/17/66 1:15 p. M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 4915 The Alameda | | | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 11/22/95 | 9. AGE (In years last birthday) 71 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Levin Bailey | | | | | 14. MOTHER'S MAIDEN NAME Mahalie Pinkett | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 219-10-7098 | | 17. INFORMANT ADDRESS Mrs. Freda Fletcher-daughter same | | | | |
| 18. 443X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Hypertensive Cardio-vascular Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Acidosis, metabolic | | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | | | |
| INTERVAL BETWEEN ONSET AND DEATH 3 years 6 days | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from December 10 19 66 to December 17 , 19 66 , that (I) (we) last saw the deceased alive on December 17 , 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE James D. Carr | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED 12-20-66 | |
| 23C. PHYSICIAN'S NAME (Type) JAMES D. CARR | | | | | 23D. ADDRESS 1427 Madison Ave | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-21-66 | | 24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park | | | 24D. LOCATION (City, town, or county) (State) Balto. Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 21 1966 | | | 25B. NAME OF REGISTRAR R. E. Faldut | | | 25C. FUNERAL DIRECTOR ADDRESS Charles R. Law, 802 Madison Ave | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|--|-----------------------------------|---|--|--|--|---|--|--|
| 66 12766 | | | | | Registered No. 66 12766 | | | | |
| BIRTH NO. 66 12766 | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED (Type or Print) MARY L. SIMS | | | | | 2. DATE AND HOUR OF DEATH 12/14/66 1 A M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL | | | | | A. STATE Maryland | | | | |
| | | | | | B. COUNTY Baltimore | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) 3602 Belle Avenue | | | | |
| 5. SEX FEMALE | | 6. RACE WHITE | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW | | 8. DATE OF BIRTH 10/5/99 | | 9. AGE (In years last birthday) 67 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) N. CAROLINA | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME HAYWARD RICHARDSON | | | | | 14. MOTHER'S MAIDEN NAME BELENSA TAYLOR | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | | 16. SOCIAL SECURITY NO. 218-54-3904 | | 17. INFORMANT ADDRESS Horace Simms - 3602 Belle Ave. | | |
| 18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) LUNG ABSCESS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CA CERVIX (underlying) | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE William H. Barber Jr. | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED 12/17/66 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | 23D. ADDRESS M.D. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-20-66 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 21 1966 | | | 25B. NAME OF REGISTRAR Robert E. Taylor | | | 25C. FUNERAL DIRECTOR ADDRESS Charles R. Law 802 Madison Ave. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|---|-----------------------------------|--|---|
| BIRTH NO. 66 12767 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12767 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Thompson, EARL | | 2. DATE AND HOUR OF DEATH 12/19/66 11.45 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) North Charles General Hospital | | D. STREET ADDRESS (If rural, give location) 3716 Woodhaven Ave. #21216 | | E. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| 5. SEX MALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 9-6-05 | 9. AGE (In years last birthday) 61 YRS. | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker | | 10B. KIND OF BUSINESS OR INDUSTRY Beth. Steel | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? United States | | 13. FATHER'S NAME William Thompson | | 14. MOTHER'S MAIDEN NAME Elizabeth Burrough | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 107-14-8304 | | 17. INFORMANT (wife) Gertrude Thompson | |
| 18. 491X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Bronchopneumonia | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH several days | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cerebral atrophy | | 19A. DATE OF OPERATION 2 | |
| 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (H) (this hospital) attended the deceased from 12-13-66 to 12-19-66 , that (H) (we) last saw the deceased alive on 12-19-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Dr. C. Suddhiman Saha | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-20-66 | |
| 23C. PHYSICIAN'S NAME (Type) DR. J. Miller | | M.D. | | 23D. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/23/66 | | 24C. NAME OF CEMETERY or CREMATORY Carver Memorial Park | |
| 24D. LOCATION (City, town, or county) Laurel, Md. | | 24E. LOCATION (City, town, or county) Laurel, Md. | | 24F. LOCATION (City, town, or county) Laurel, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR Charles Q. Rice | | 25C. FUNERAL DIRECTOR Charles Q. Rice | |
| 25D. ADDRESS | | 25E. ADDRESS | | 25F. ADDRESS | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 12768 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12768 | |
|--|--|--|--|---|--|-------------------------|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) WILLIAM EDWARD BROTEMARKLE | | | | 2. DATE AND HOUR OF DEATH 12/21/66 2:05 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION FRANKLIN SQUARE HOSPITAL 36 | | | | A. STATE MARYLAND | | | |
| (If not in hospital or institution, give street address or location) | | | | B. COUNTY | | | |
| 5. SEX MALE | | | | 6. RACE WHITE | | | |
| 7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | | | | 8. DATE OF BIRTH 5/24/1906 | | | |
| 9. AGE (In years lost birthday) 60 | | | | 10. AGE (In years lost birthday) 60 | | | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | |
| 13. FATHER'S NAME WILLIAM C. BROTEMARKLE | | | | 14. MOTHER'S MAIDEN NAME BESSIE EVANS | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. 213-05-9278 | | | |
| 17. INFORMANT CATHERINE BROTEMARKLE (WIFE) | | | | ADDRESS | | | |
| 18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) DUE TO | | | |
| (B) DUE TO | | | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| 20A. AUTOPSY? (Yes or No) | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/20 19 66 to 12/21 19 66 , that (I) (we) last saw the deceased alive on 12/21 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Thomas G. Alvero | | | | 23B. DATE SIGNED 12/21/66 | | | |
| 23C. PHYSICIAN'S NAME (Type) TOMAS A. ALVERO | | | | 23D. ADDRESS FRANKLIN SQUARE HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | | 24B. DATE 12-24-66 | | | |
| 24C. NAME OF CEMETERY or CREMATORY FORT LINCOLN | | | | 24D. LOCATION (City, town, or county) (State) PRINCE GEORGE CTY MD. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 21 1966 | | | | 25B. NAME OF REGISTRAR Robert E. Johnson | | | |
| 25C. FUNERAL DIRECTOR Geo. L. Schwab | | | | ADDRESS Francis W. Miller 2101 Frederick Ave | | | |

P-632

66 12769

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66 12769

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

STANLEY B. PRIDEAUX Jr.

2. DATE AND HOUR PRONOUNCED DEAD

December 17, 1966 10:25 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

46 Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1632 Warwick Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Separated

8. DATE OF BIRTH

Feb 12, 1943

9. AGE (In years
last birthday)

23

If Under 1 Yr. II Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Stanley B. Prideaux Jr.

14. MOTHER'S MAIDEN NAME

Clara Dennis

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give year or dates of service)

Yes

WW II

16. SOCIAL
SECURITY NO.

217-38-8101

17. INFORMANT

Delmar Prideaux

ADDRESS

1017 W. Landon St.

18. I-9821X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Stab Wound of Chest.
DUE TO

(B) DUE TO

(C) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

Front of 1658 Warwick Avenue

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
12 17 '66 P

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Stabbed during altercation.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/18/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/21/66

23C. NAME of CEMETERY or CREMATORY

Baltimore National

23D. LOCATION

(City, town, or county)

(State)

Baltimore Md.

24A. DATE REC'D BY HEALTH DEPT.

DEC 21 1966

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Arlington S. Phillips

ADDRESS

1727 N. Monmouth St.

USE FOR CONTENT

WALLS FORGE

UNITED

1912-1913

1913-1914

1914-1915

1915-1916

1916-1917

1917-1918

1918-1919

1919-1920

1920-1921

1921-1922

1922-1923

1923-1924

1924-1925

1925-1926

1926-1927

1927-1928

1928-1929

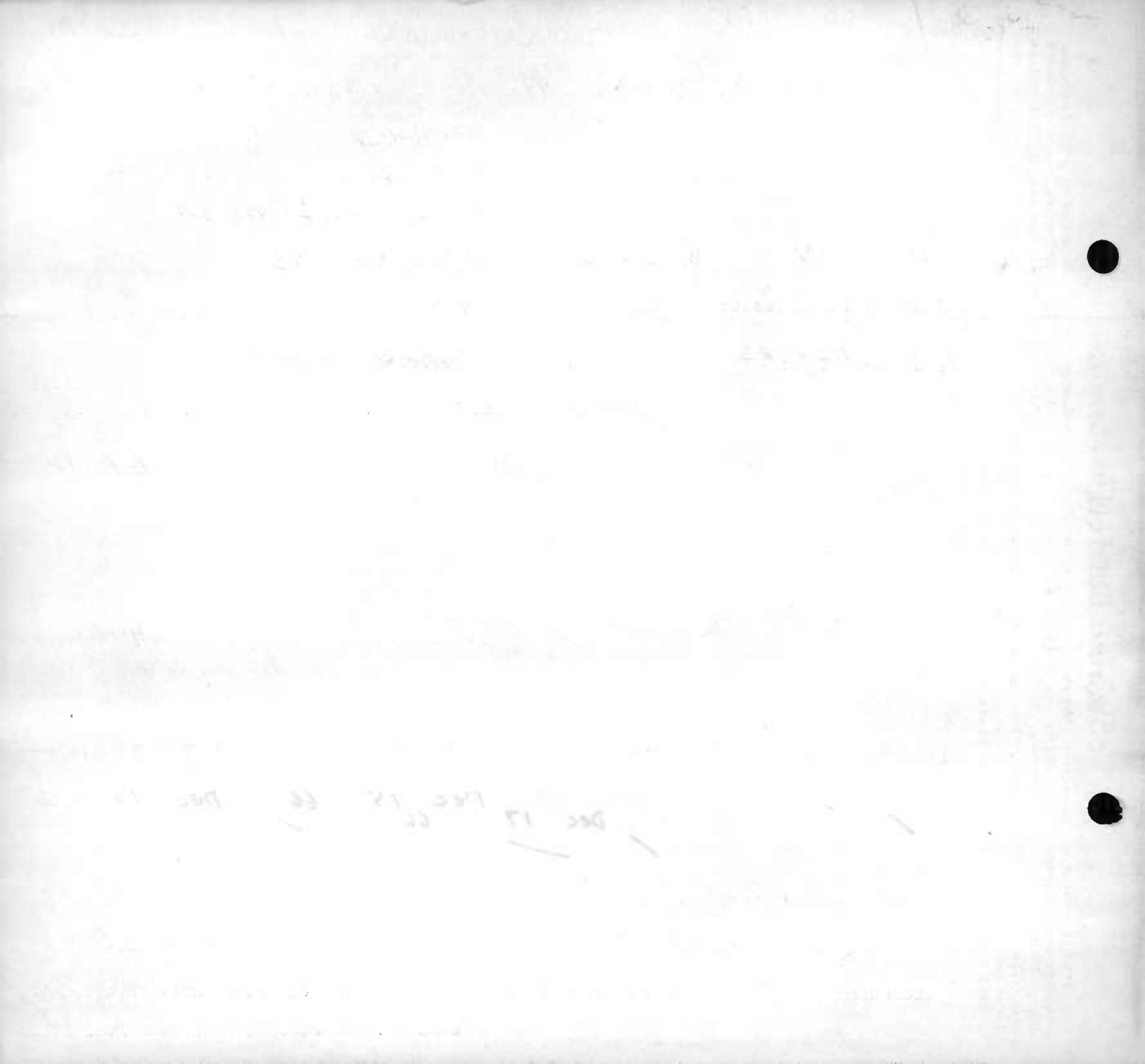
1929-1930

1930-1931

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

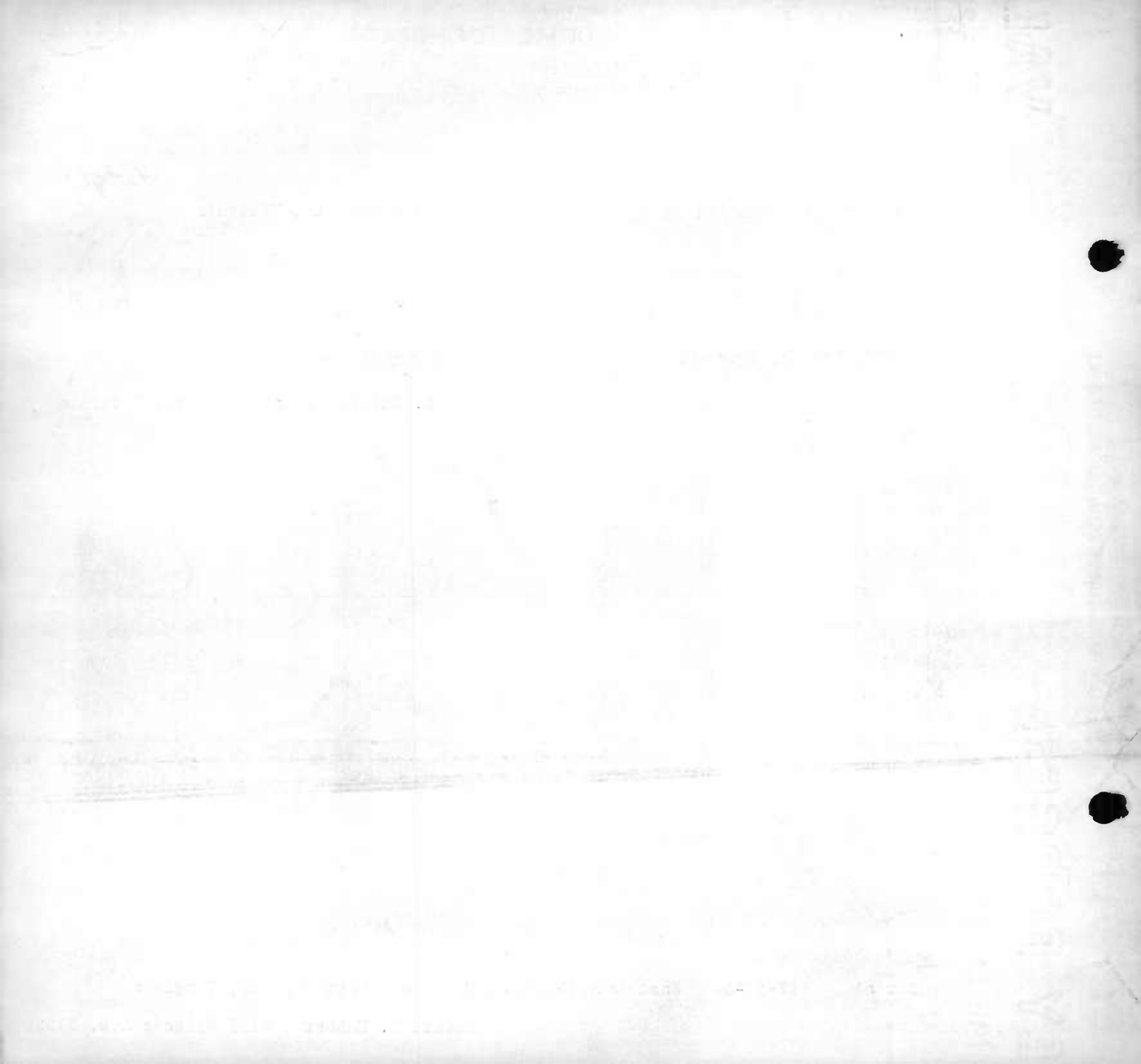
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 12770</u> | |
|---|---------------------|---|------------------------------------|---|--|
| BIRTH NO. <u>66 12770</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>MAYERS, GEORGE W.</u> | | 2. DATE AND HOUR OF DEATH <u>DEC 17, 1966</u> <u>74</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>34 BON SECOURS</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> | | D. STREET ADDRESS (If rural, give location) <u>411 N. Chapel Gate LA</u> | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>W. WIDOWED</u> | 8. DATE OF BIRTH <u>2/19/83</u> | 9. AGE (In years lost birthday) <u>83</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>B & O Station Master</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Retired</u> | | 11. BIRTHPLACE (State or foreign country) <u>N.Y.</u> | |
| 13. FATHER'S NAME <u>W. H. AMMAYERS</u> | | 14. MOTHER'S MAIDEN NAME <u>XXXXXXXX Harriette Young</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>714-01-6880</u> | | 17. INFORMANT <u>Mr. Vernon R. DeVinney, 411 N. Chapel Gate La.</u> | |
| 18. I <u>162.1</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Bronchogenic Ca</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Emphysema & Cor Pulmonale</u> | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH <u>6 Months</u> <u>YEARS</u> | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Dec 15</u> 19 <u>66</u> to <u>Dec 17</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec 17</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>S. Gennaro</u> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>12-17-66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Doctor Berry, Robert Z.</u> | | 23D. ADDRESS <u>211 Medical Arts Baltimore Md.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u> | | 24B. DATE <u>12-19-66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park Cemetery</u> | |
| 24D. LOCATION <u>3801 Frederick Ave. Balto., Md.</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 21 1966</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Farber</u> | | 25C. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u> | |



FUNERAL DIRECTOR: IMPORTANT

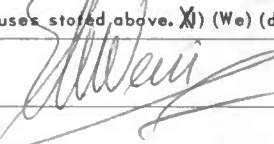
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|---------------------|--|---|---|--|--|--|--|---------|
| 66 12771 | | | | | 66 12771 | | | | |
| BIRTH NO. | | | | | REGISTERED No. | | | | |
| M.E. CASE NO. | | | | | CERTIFICATE OF DEATH | | | | |
| 1. NAME OF DECEASED (Type or Print) Katherine Lapsley Stickley <i>KATHERINE L. STICKLEY</i> | | | | | 2. DATE AND HOUR OF DEATH <i>12/19/66</i> <i>7:50 a.m.</i> M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>33</i> The Johns Hopkins Hospital | | | | | A. STATE <i>Pa.</i> B. COUNTY <i>Penn LAIRD</i> | | | | |
| (If not in hospital or institution, give street address or location) | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>PENN LAIRD. V-43</i> | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) <i>Harrisonburg, Virginia</i> | | | | |
| 5. SEX <i>F</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>M</i> | 8. DATE OF BIRTH <i>06-29-04</i> | 9. AGE (In years lost birthday) <i>62</i> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY — | | 11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | |
| 13. FATHER'S NAME <i>William W. Sproul</i> | | | | | 14. MOTHER'S MAIDEN NAME <i>Katherine Lapsley</i> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i> | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Don C. Stickley, Harrisonburg, Virginia</i> | | | | ADDRESS |
| 18. <i>450.01</i> CAUSE OF DEATH | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>RENAL FAILURE</i> | | | | | (A) DUE TO | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (B) DUE TO <i>USCULITIS</i> | | | | |
| | | | | | (C) <i>3 MET.</i> | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) <i>LIMITED TO 450</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>12/1/66</i> to <i>12/19/66</i> and that (I) (we) last saw the deceased alive on <i>12/15/66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <i>John C. Whelton</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | | 23B. DATE SIGNED <i>12/19/66</i> | | | | |
| 23C. PHYSICIAN'S NAME (Type) <i>JOHN C. WHELTON</i> M.D. | | | | | 23D. ADDRESS <i>1620 McELDERRY ST. BALTIMORE MD 21205</i> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12-21-66</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>East Lawn Memorial Gardens</i> | | | 24D. LOCATION (City, town, or county) (State) <i>Harrisonburg, Virginia</i> | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 21 1966</i> | | | 25B. NAME OF REGISTRAR <i>R. E. F.</i> | | | 25C. FUNERAL DIRECTOR ADDRESS <i>Howard H. Hubbard, 4107 Wilkens Ave. 21229</i> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 12772</u> | |
|---|--------------------------------|--|--|---|---|
| <div style="display: flex; justify-content: space-between;"> BIRTH NO. <u>66 12772</u> CERTIFICATE OF DEATH </div> | | | | | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <u>WITTMAN, CHARLES J.</u> | | | 2. DATE AND HOUR OF DEATH <u>DECEMBER 18, 1966 12:30P. M.</u> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND <div style="text-align: center;"> ST. AGNES HOSPITAL FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>WILKENS & CATON AVES.</u> <u>BALTO., MD. 21229</u> </div> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY _____ C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE 21229</u> D. STREET ADDRESS (If rural, give location) <u>88 3120 WILKENS AVENUE</u> | | |
| 5. SEX <u>MALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED, NEVER MARRIED <u>MARRIED</u> WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH <u>1-21-94</u> | 9. AGE (In years lost birthday) <u>72</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STEAMFITTER</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Retired</u> | | 11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u> | |
| 13. FATHER'S NAME <u>GEORGE Wittman</u> | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>216-01-4388</u> | | 17. INFORMANT <u>WILKENS & CATON AVES</u> <u>ST. AGNES HOSPITAL BALTIMORE, MD. 21229</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. If means the disease, injury or complication which caused death.) <u>ASCVD</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Acute MI</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>18 months</u> | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>DEC. 18, 1966</u> to <u>DEC. 18, 1966</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>DEC. 18, 1966</u> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <u>XXXX</u> view the body after death. | | | | | |
| 23A. SIGNATURE  | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) <u>E.M. WEISS,</u> | | 23D. ADDRESS <u>WILKENS & CATON AVES</u> <u>ST. AGNES HOSPITAL BALTO., MD. 21229</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12-21-66</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Loudon Park Cemetery</u> | |
| 24D. LOCATION (City, town, or county) <u>21229</u> | | <u>3801 Frederick Ave., Balto., Md.</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 21 1966</u> | | 25B. NAME OF REGISTRAR <u>E. J. J. J.</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u> | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Bodily burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12773 | |
|---|-------------------------|--|--|---|---|
| BIRTH NO. 66 12773 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Vaupel, John G.</i> | | 2. DATE AND HOUR OF DEATH <i>December 14, 1966</i> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>House in the Piney-Belt Area</i> | | (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | |
| D. STREET ADDRESS <i>2000 McKean Ave.</i> | | (If rural, give location) | | 21217 | |
| 5. SEX <i>Male</i> | 6. RACE <i>White</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Single</i> | 8. DATE OF BIRTH <i>Dec. 28, 1902</i> | 9. AGE (In years lost birthday) <i>63</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>M. S. Levy - Printer</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Mens Straw Hats</i> | | 11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i> | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME <i>George Vaupel</i> | | 14. MOTHER'S MAIDEN NAME <i>Lillie Meine</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>None</i> | | 17. INFORMANT ADDRESS <i>Mrs. Timothy Smither 3122 Brendan Ave.</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Cachexia</i> | | CAUSE OF DEATH (A) DUE TO <i>Esophageal Obstruction</i> (B) DUE TO <i>Carcinoma of Esophagus</i> (C) | | INTERVAL BETWEEN ONSET AND DEATH <i>1 month</i> | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>II</i> | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Dec 8 12/8 1966</i> to <i>12/14 1966</i> and that (I) (we) last saw the deceased alive on <i>Dec 8 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Albert B. Bradley</i> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>12/14/66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Albert B. BRADLEY</i> | | M.D. 23D. ADDRESS <i>4910 Belair Rd. Balto., Md. 21206</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12/17/1966</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Loudon Park Cemetery</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 21 1966</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Taylor</i> | |
| 25C. FUNERAL DIRECTOR <i>Wm. J. Tichner & Sons</i> | | ADDRESS <i>Baltimore, Md.</i> | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 66 12774 | |
|--|------------------|--|---------------------------------|---|----------------------------|---|-----------------------------|
| BIRTH NO. 66-12774 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type) E. S. MAC BROWN. | | 2. DATE AND HOUR OF DEATH 12-19-66 9:10 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) | | CITY OR TOWN (If outside city limits, write RURAL and give township) | | A. STATE | | B. COUNTY | |
| 35 Church Home & Hospital | | BALTIMORE | | M.D. | | | |
| | | D. STREET ADDRESS (If rural, give location) | | 1206 JOHN ST. | | 21217 | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED (specify) | 8. DATE OF BIRTH 5-25-92 | 9. AGE (In years last birthday) 74 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) USA | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME CHARLES SKINNER | | | | 14. MOTHER'S MAIDEN NAME CORA BELLOES | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 315-225740 | | 17. INFORMANT Mrs. Barbara B. Mahon same address | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 584X I | | Acute Myocardial Infarction | | ? | | | |
| ANTECEDENT CAUSES | | (A) DUE TO | | (B) DUE TO | | (C) DUE TO | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | ASHD | | PNEUMONIA | | | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | SEPTICEMIA; Bacteremia | | | |
| 19A. DATE OF OPERATION 12-9-66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED GALLSTONE ILEUS | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While <input type="checkbox"/> At Work Not While <input type="checkbox"/> At Work | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-8-66 1966 to 12-19- 1966, that (I) (we) last saw the deceased alive on 12-19 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Asst. M.D. | | | | 23B. DATE SIGNED 12-19-66 | | | |
| 23C. PHYSICIAN'S NAME (Type) DR. MASON KNOX | | | | 23D. ADDRESS Church Home & Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Removal | | 24B. DATE 12/21/1966 | | 24C. NAME of CEMETERY or CREMATORY Forest Lawn Cemetery | | 24D. LOCATION (City, town, or county) (State) Charlotte, N. C. | |
| 25A. DATE RECD BY HEALTH DEPT. DEC 21 1966 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Wm. J. Tinkensons | | ADDRESS Balto., Md North Ave | |

2-19-66

2-19-66

MD.
Baltimore
1206 John St. 21514
2-22-66
VSA
Core & Hoes

Church Home & Hospital
F W
Housewife
Charles Skinner

~~Acute Myocardial Infarction~~
A243
Inventor

Septicemia, fatal

12-9-66 Baltimore 1206 John St.

12-11-66 12-8-66 12-19-66

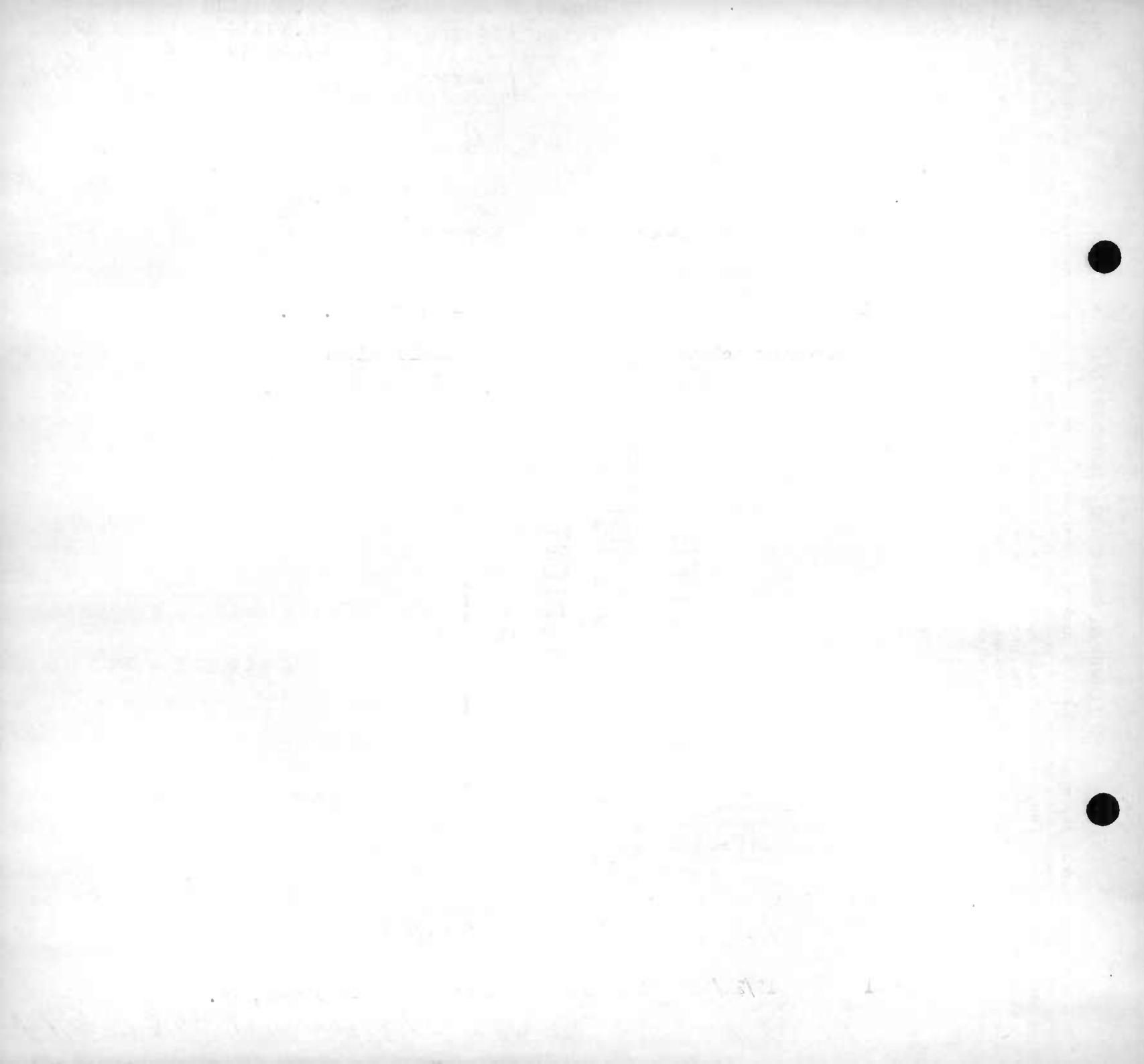
12-19-66
Church Home & Hospital

DeMason Knox
Baltimore

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

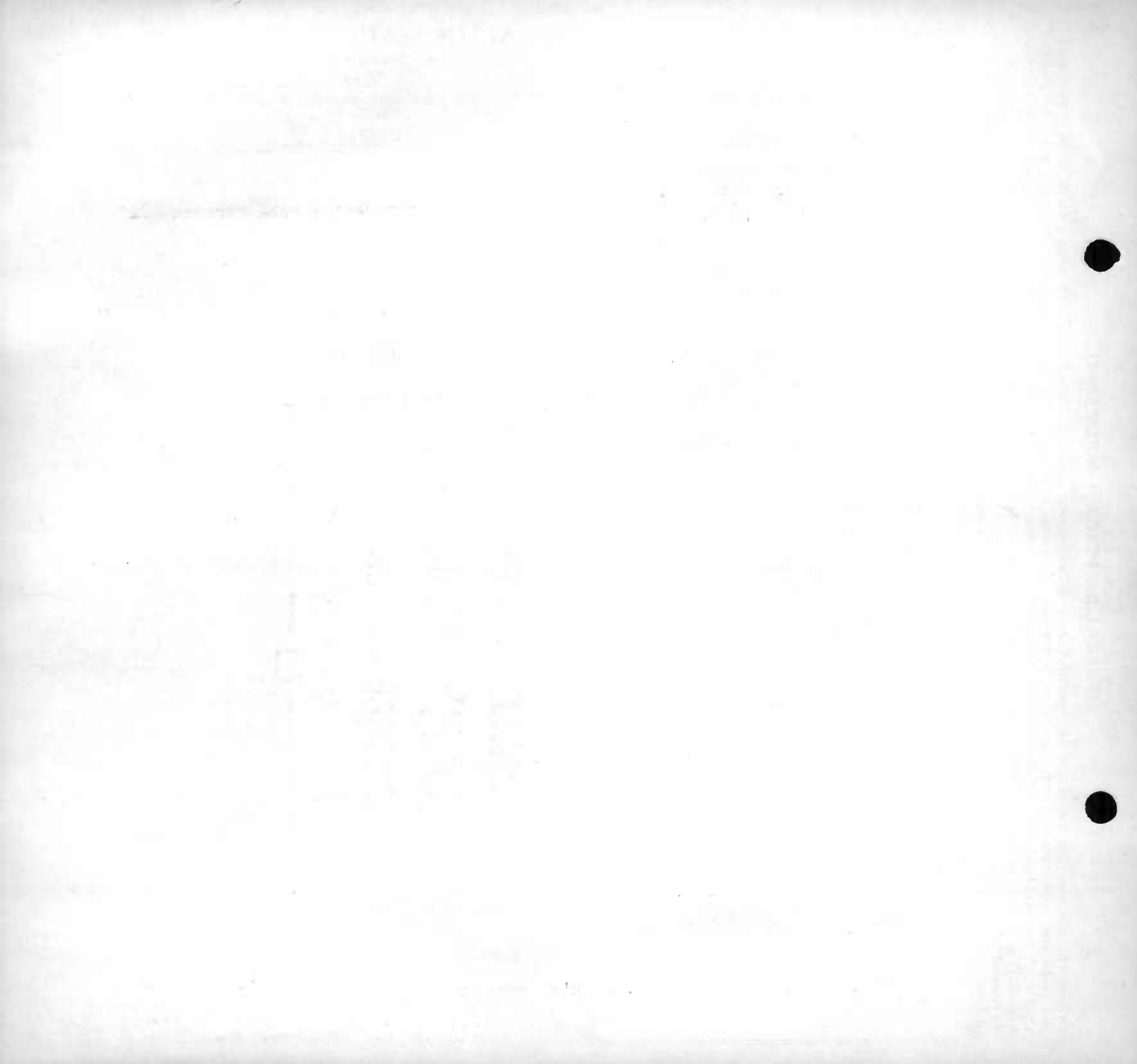
| BALTIMORE CITY HEALTH DEPARTMENT | | | | DR. HORNICK | | 3-412 | |
|--|--|--|--|---|--|--|--|
| BIRTH NO. | | | | 66 12775 | | 66 12775 | |
| M.E. CASE NO. | | | | 03-57-49 | | G M | |
| 1. NAME OF DECEASED (Type or Print) | | | | ECKMAN JAY Raymond | | 2. DATE AND HOUR OF DEATH 12-18-66 730 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE MD. | | | |
| UNIV. HOSP. BALTO. I, MD 38 | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. 18-01 | | | |
| D. STREET ADDRESS (If rural, give location) | | | | 868 W. BALTO ST. | | | |
| 5. SEX M | | 6. RACE W | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Sep. | | 8. DATE OF BIRTH 7/31/97 | |
| 9. AGE (in years last birthday) 69 | | 10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Lancaster Co. Pa. | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | 13. FATHER'S NAME Christopher Eckman | | | |
| 14. MOTHER'S MAIDEN NAME Mamie Knight | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT JAY C. ECKMAN - SON - 923 BARRE ST. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH LAENNEC'S CIRRHOSIS | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) DUE TO | | (B) DUE TO | |
| (C) DUE TO | | | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. OLIGURIA 13 DAYS PRIOR TO DEATH | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from 12/3 1966 to 12/18 1966, that (I) (we) last saw the deceased alive on 12/18 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE Stuart L Fine | |
| 23B. DATE SIGNED 12/18/66 | | 23C. PHYSICIAN'S NAME (Type) STUART L FINE | | 23D. ADDRESS UNIV HOSP | | 23E. M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/21/66 | | 24C. NAME of CEMETERY or CREMATORY Riverview Burial Park | | 24D. LOCATION (City, town, or county) (State) Lancaster, Pa. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 21 1966 | | 25B. NAME OF REGISTRAR Robert E. Fink | | 25C. FUNERAL DIRECTOR Wm. T. Hark & Sons | | 25D. ADDRESS North 4th St. Balto, Md | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

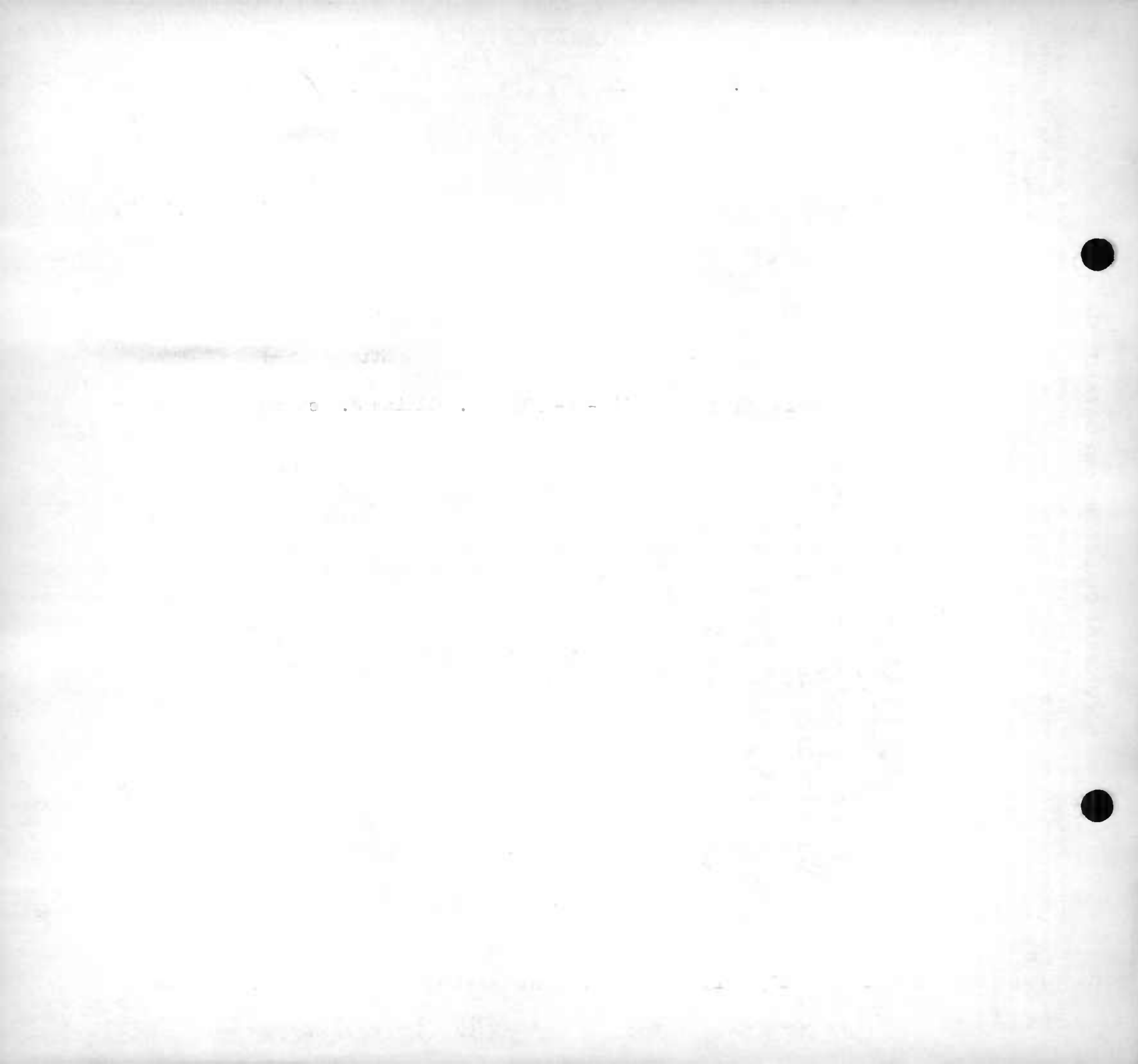
| BIRTH NO. 66 12776 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12776 | |
|--|---------------------|---|--|--|--|--|-----------------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) MARY ARMOUR JENKINS SMITH | | | | 2. DATE AND HOUR OF DEATH December 19, 1966 | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 91 Jenkins Memorial Hospital 1000 S. Caton Ave. Baltimore, Md. 21229 | | (If not in hospital or institution, give street address or location) | | A. STATE MARYLAND | | B. COUNTY | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | D. STREET ADDRESS (If rural, give location) 5407 Falls Road Terrace 10 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | D. STREET ADDRESS (If rural, give location) 5407 Falls Road Terrace 10 | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH May 1, 1890 | 9. AGE (in years, lost birthday) 76 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Richard Hillen Jenkins | | | | 14. MOTHER'S MAIDEN NAME Mary Josephine Armour | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 035 16 2979 | | 17. INFORMANT Medical Records - (M D Kohler) | | ADDRESS | |
| 18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) DUE TO Cerebro Vascular Accident years (B) DUE TO Gen. arteriosclerosis years (C) Chr. Brain syndrome years | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from JUNE 1966 to DEC 1966 , that (I) (we) last saw the deceased alive on 12-19 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Manuel Rodriguez, M.D. | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 12-19-66 | |
| 23C. PHYSICIAN'S NAME (Type) Manuel Rodriguez | | | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/22/1966 | | 24C. NAME OF CEMETERY or CREMATORY St. John's Cemetery | | 24D. LOCATION (City, town, or county) (State) Long Green, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 21 1966 | | 25B. NAME OF REGISTRAR Robert E. Johnson | | 25C. FUNERAL DIRECTOR Wm. F. Tichner & Sons | | ADDRESS Balt. Md. north 2nd Pa. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

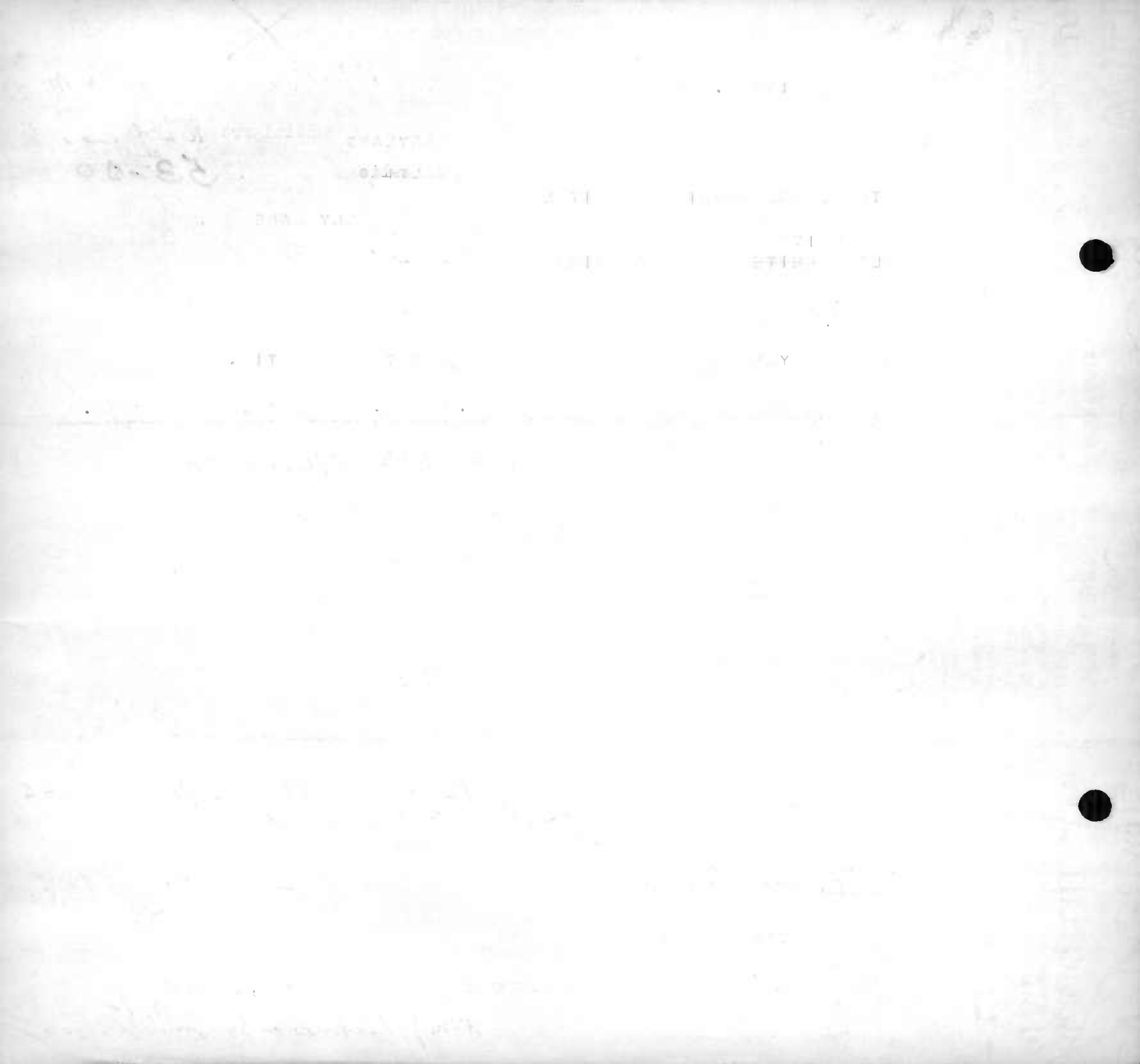
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. | |
|---|--|--|--|--|--|---|--|--|--|---|--|
| BIRTH NO. | | 66 12777 | | CERTIFICATE OF DEATH | | | | 66 12777 | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | | | | | |
| | | John Edward WARREN | | 12/18/66 | | | | | | 125 A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | | | A. STATE B. COUNTY | | | | | |
| Union Mem Hosp. 44 BALT. Md. | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | | |
| | | | | | | D. STREET ADDRESS (If rural, give location) | | | | | |
| | | | | | | 306 E UNIVERSITY PKWY | | | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | 10. If Under 1 Yr. Months Days Hours Min. | |
| m | | cauc | | single | | 7/29/94 | | 72 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Never Worked | | | | | | | | WASHINGTON DC | | US | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | | | | | |
| EDWARD WARREN | | | | Etta Ward | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | ADDRESS | |
| Yes World War I | | | | 220-54-9305 | | Mr. William J. Kennedy | | | | same address | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) | | | | (A) DUE TO | | | | Colon | | | |
| ANTECEDENT CAUSES | | | | (B) DUE TO | | | | Carcinoma of stomach with metastases. | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 12/15/66 | | | | obstruction | | | | no | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | | | 21E. INJURY OCCURRED | | | | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | While At <input type="checkbox"/> Not While Work At Work <input type="checkbox"/> | | | | | | | |
| 22. I certify that (H) (this hospital) attended the deceased from 12/2 19 66 to 12/18 19 66. that (H) (we) last saw the deceased alive on 12/18/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | | | | | |
| Robert P. Doyle | | | | 12/18/66 | | | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | | | | | |
| | | | | M.D. | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | | | 24D. LOCATION (City, town, or county) (State) | | | |
| Burial | | 12/20/1966 | | Green Mount Cemetery | | | | Baltimore, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | | | ADDRESS | | | |
| DEC 21 1966 | | Robert E. Feltus | | Wm. J. Feltus & Sons | | | | Baltimore, Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12778 | |
|---|--|--|---|--|--|
| BIRTH NO. 66 12778 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | RITA K. STARKS | | 12/18/66 5:15 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS HOSPITAL | | | A. STATE B. COUNTY Maryland Baltimore Balto. Co. | | |
| (If not in hospital or institution, give street address or location) | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Anneslie | | |
| | | | D. STREET ADDRESS (If rural, give location) 6301 HOLLY LANE | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months; Days If Under 24 Hrs. Hours; Min. |
| FEMALE | WHITE | MARRIED | 10-17-28 | 51 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 12. CITIZEN OF WHAT COUNTRY? | |
| Housewife | | | | Maryland | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| EDMUND RYAN | | | GERTRUDE CURTIS. | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| No None | | | Mr. John C. Starks 6316 Blackburn Ct. | | |
| 18. CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) DUE TO METASTATIC MELANOMA (B) DUE TO (C) DUE TO | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 2 | | YES | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/6 to 12/18 1966, that (I) (we) last saw the deceased alive on 12/18 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | 23B. DATE SIGNED | | |
| Peter J. Rosen | | | 12/18/66 | | |
| 23C. PHYSICIAN'S NAME (Type) | | | 23D. ADDRESS | | |
| PETER ROSEN | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | 12/20/1966 | Lorraine Park Cemetery | | Woodlawn, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | 25B. NAME OF REGISTRAR | 25C. FUNERAL DIRECTOR ADDRESS | | | |
| DEC 21 1966 | Robert E. Fadden | Wm. J. Fickner + Son Baltimore, Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 12779 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12779 | |
|--|--------------|---|--|--|---|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) ASHTON S. CAMMANN | | | | 2. DATE AND HOUR OF DEATH 12/18/66 12:00 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 Md Gen Hosp. BALTO., Md. 21201 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 14-01 D. STREET ADDRESS (If rural, give location) 1701 EUTAW PLACE | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH 09/06/1969 | 9. AGE (In years last birthday) 69 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK AT BALTO WATER DEPT. | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Md | | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | 13. FATHER'S NAME WILLIAM CAMMANN | | | | |
| 14. MOTHER'S MAIDEN NAME SUSAN SHEPPARD | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | |
| 16. SOCIAL SECURITY NO. 213-12-4711 | | | 17. INFORMANT ADDRESS Kenneth R Koskenen MD | | | | |
| 18. 420.117/56.2 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) CARDIAC ARREST - FIBRILLATION 48 hrs (B) MYOCARDIAL INFARCTION (C) ASCVD | | | |
| INTERVAL BETWEEN ONSET AND DEATH 48 hrs | | | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. retained to the left lobe NAPKIN constricting lesion transverse colon? CA. | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/17 1966 to 12/18 1966, that (I) (we) last saw the deceased alive on 12/18 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Kenneth R. Koskenen MD | | | | 23B. DATE SIGNED 12/18/66 | | | |
| 23C. PHYSICIAN'S NAME (Type) M.D. | | | | 23D. ADDRESS Md Gen Hosp. BALTO, Md | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/22/1966 | | 24C. NAME OF CEMETERY or CREMATORY Oaklawn Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore County, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR DEC 21 1966 R. E. Farley MD | | 25C. FUNERAL DIRECTOR Wm. F. Johnson | | 25D. ADDRESS Baltimore, Md. | |

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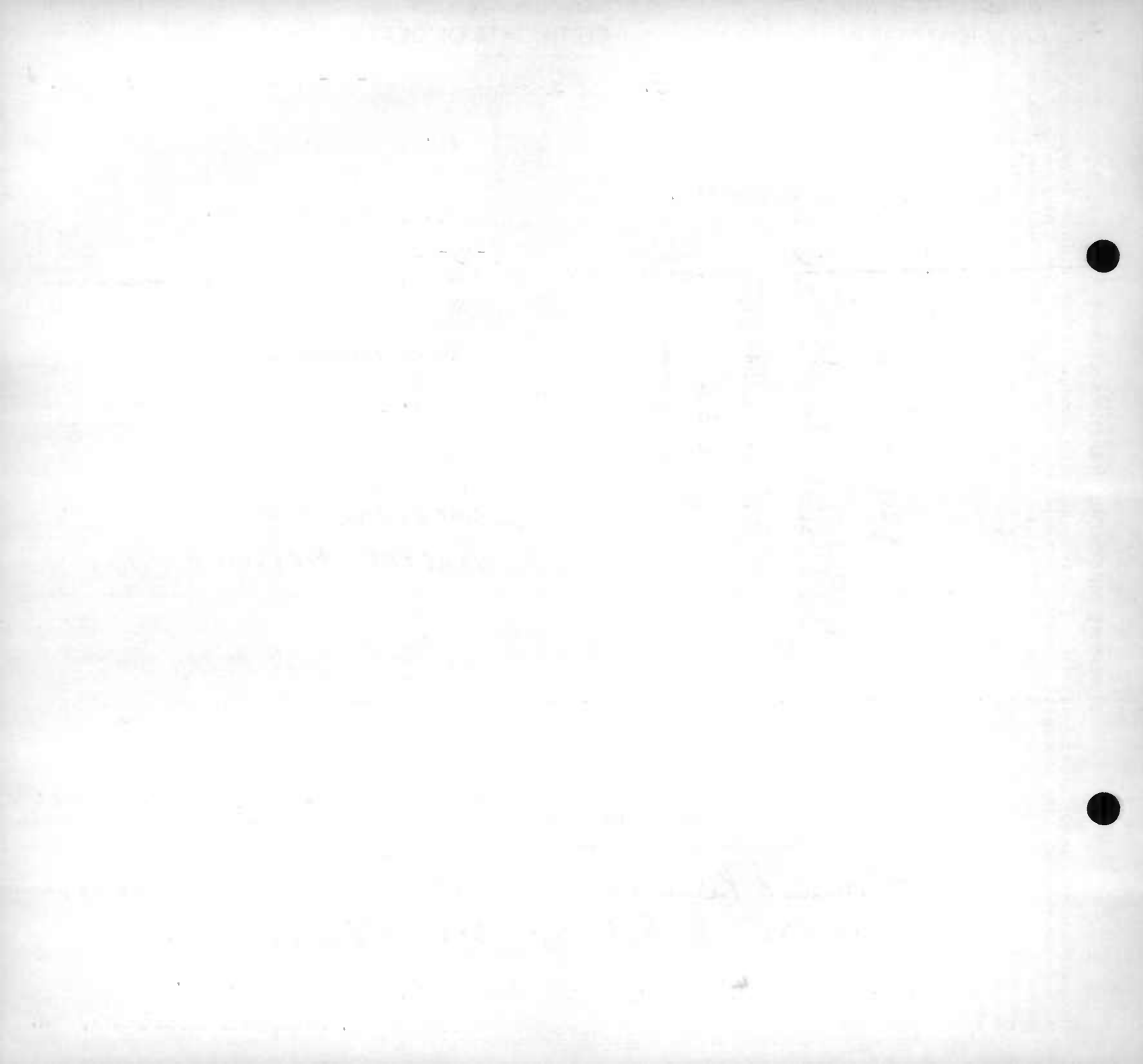
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

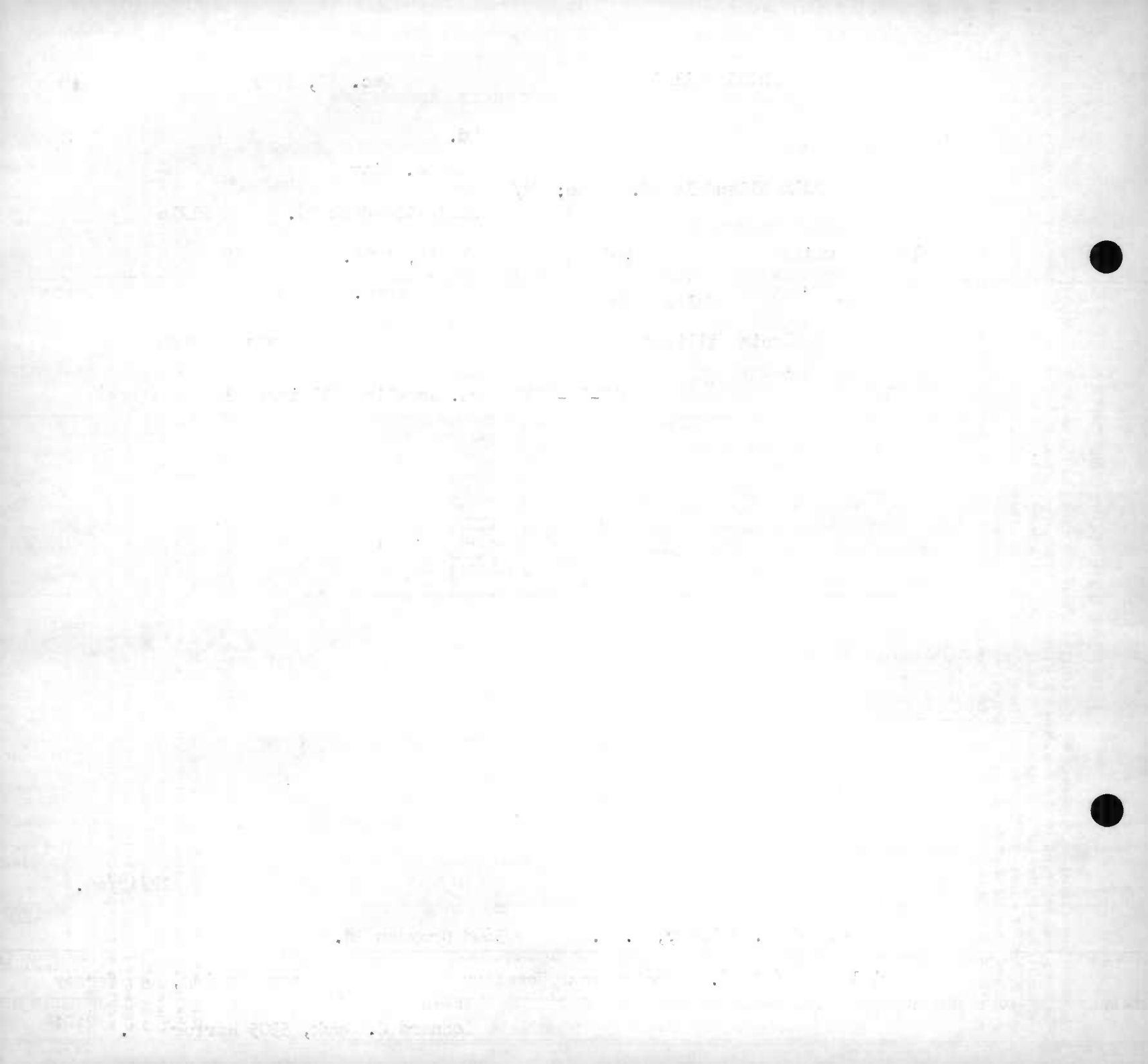
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. <u>66 12780</u> | |
|--|--|------------------------------|--|--|--|--------------------------------------|--|--|--|---|--|
| BIRTH NO. <u>66 12780</u> | | | | | | | | | | Certificate of Death | |
| M.E. CASE NO. | | | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Barbara J. Giles</u> | | | | | 2. DATE AND HOUR OF DEATH <u>12-21-1966</u> <u>12:10 A.</u> M. | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>4617 Mannasota Ave.</u> | | | | | A. STATE <u>Md.</u> B. COUNTY | | | | | | |
| (If not in hospital or institution, give street address or location) | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) <u>4617 Mannasota Ave.</u> | | | | | | |
| 5. SEX <u>female</u> | | 6. RACE <u>white</u> | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>widowed</u> | | 8. DATE OF BIRTH <u>9-15-1891</u> | | 9. AGE (In years last birthday) <u>75</u> | | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | 13. FATHER'S NAME <u>Ambrose Fritsch</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Helen Tochtermann</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> | | | | | 16. SOCIAL SECURITY NO. <u>220096713A</u> | | | | | 17. INFORMANT <u>John T. Giles</u> | |
| ADDRESS <u>same</u> | | | | | | | | | | | |
| 18. <u>260X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH (A) <u>ARTERIO SCLEROTIC</u> DUE TO <u>C-V. DISEASE C</u> (B) <u>GLOMERULAR NEPHRITIS</u> DUE TO (C) <u>DIABETES MELLITUS</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1963</u> <u>1964</u> <u>1962</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>MAY</u> 19 <u>62</u> to <u>DEC</u> <u>21</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>DEC 20</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE <u>Norman R. Kleiman</u> | | | | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>12/21/66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>NORMAN R. KLEIMAN</u> | | | | | | | | 23D. ADDRESS <u>3803 Edmondson Ave</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u> | | 24B. DATE <u>12/24/66</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Holy Redeemer Cemetery</u> | | | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 21 1966</u> | | | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | | | 25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc Baltimore, Md.</u> | | | |
| ADDRESS | | | | | | | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 12781</u> | |
|---|-------------------------|--|---|--|---|
| BIRTH NO. <u>66 12781</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Philip Williams</u> | | 2. DATE AND HOUR OF DEATH <u>Dec. 17, 1966</u> <u>1 10 30 A.</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>00</u> | | A. STATE <u>Md.</u> B. COUNTY <u>Balto. City</u> | | | |
| (If not in hospital or institution, give street address or location) <u>2114 Allendale Rd. Balto; Md/ 21216</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Balto. City</u> | | | |
| | | D. STREET ADDRESS (If rural, give location) <u>2114 Allendale Rd. 21216</u> | | | |
| 5. SEX <u>male</u> | 6. RACE <u>white</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u> | 8. DATE OF BIRTH <u>July 17, 1900.</u> | 9. AGE (In years last birthday) <u>66</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Self-Employed</u> | | 11. BIRTHPLACE (State or foreign country) <u>Penna.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>Louis Williams</u> | | 14. MOTHER'S MAIDEN NAME <u>Maria Scarano</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>217-32-9532A</u> | | 17. INFORMANT <u>Mrs. Angelina Williams</u> | |
| | | | | ADDRESS (Same) | |
| 18. <u>137X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteemia, etc. It means the disease, injury or complication, which caused death.) <u>Cerebral Vascular Accident</u> | | CAUSE OF DEATH (A) DUE TO <u>Carcinoma of Pancreas with metastasis to Liver and Right Scapula</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>6 months</u> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | (C) <u>and Right Scapula</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12/14/66</u> 19 to <u>12/17/66</u> 19, that (I) <u>we</u> last saw the deceased alive on <u>12/17/66</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Joseph N. Zeirler</u> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>12/18/66.</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Joseph N. Zeirler, M. D.</u> | | 23D. ADDRESS <u>3608 Croyden Rd.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12/21/66.</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Holy Cross Cemetery</u> | |
| | | | | 24D. LOCATION (City, town, or county) (State) <u>Mays Landing, New Jersey</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 21 1966</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR <u>Leonard J. Ruck, 5305 Harford Rd. 21214</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 12782 | | | | CERTIFICATE OF DEATH | | Registered No. 66 12782 | |
|--|---------------------|---|--|--|--|---|--|
| 1. NAME OF DECEASED (Type or Print) <i>Bezusko, William J.</i> | | | | 2. DATE AND HOUR OF DEATH <i>Dec. 19, 1966 6:45 P.M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>35 Church Home & Hosp.</i> | | (If not in hospital or institution, give street address or location) | | A. STATE <i>Maryland</i> | | B. COUNTY | |
| | | | | C. CITY OR TOWN (If outside city limits, give RURAL and give township) <i>Baltimore</i> | | | |
| | | | | D. STREET ADDRESS (If rural, give location) <i>243 S. Wolfe St.</i> | | | |
| 5. SEX <i>M</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED, <input type="checkbox"/> DIVORCED (specify) <i>Widowed</i> | | 8. DATE OF BIRTH <i>1-1-1922</i> | | 9. AGE (In years last birthday) <i>44</i> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Test maker (Retired)</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Calmd</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>John Bezusko</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Catherine Kiselski</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes WW 1</i> | | 16. SOCIAL SECURITY NO. <i>Unk.</i> | | 17. INFORMANT <i>Emily Schudel</i> | | ADDRESS <i>4115 La Salle Rd.</i> | |
| 18. <i>625X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | (A) DUE TO <i>cardiac arrest</i> | | | |
| | | | | (B) DUE TO <i>Cor Pulmonale</i> | | | |
| | | | | (C) <i>Severe chronic Pulmonary Fibrosis</i> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION <i>10-17-66</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Resp. insuff.</i> | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED White <input type="checkbox"/> At Work Not White <input type="checkbox"/> At Work | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Dec. 16</i> 19 <i>66</i> to <i>Dec. 19</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>Dec. 19</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Rehmy</i> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>12/19/66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Nemita Suarez</i> | | 23D. ADDRESS M.D. <i>Church Home & Hosp.</i> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12/23/66</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Gate of Heaven Cemetery</i> | | 24D. LOCATION (City, town, or county) (State) <i>Hanover, N.J.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 21 1966</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Salama</i> | | 25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc.</i> | | ADDRESS <i>Balto. Md. 21214</i> | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 12783 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12783 | |
|---|--|--|--|---|--|
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) NAOMI MEYERS | | 2. DATE AND HOUR OF DEATH 12/19/66 11:09 AM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-00 D. STREET ADDRESS (If rural, give location) MARYLAND | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland General Hospital | | 5. SEX FEMALE | | 6. RACE CAUCASIAN | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED | | 8. DATE OF BIRTH 3/20/66 | | 9. AGE (In years last birthday) 60 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEERING CLERK | | 10B. KIND OF BUSINESS OR INDUSTRY MTI | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME LOUIS ROKEI | | 14. MOTHER'S MARDEN NAME Kate ALTUATER | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 214-68580 | | 17. INFORMANT ADDRESS Mrs. Lois Peregoy- 1816 Wycliffe Rd. #34 | |
| 18. 420.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) PULMONARY EDEMA | | CAUSE OF DEATH (A) DUE TO ARTEROSCLEROTIC HEART DISEASE (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ARTEROSCLEROTIC PERIPHERAL VASCULAR DISEASE | | | |
| 19A. DATE OF OPERATION 12-17-66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Peripheral Vascular Dis. | | 20A. AUTOPSY? (Yes or No) Yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from 12-12-1966 to 12-19-1966 that (I) (we) last saw the deceased alive on 12-19-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <input checked="" type="checkbox"/> (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Ronald D. Snyder, M.D. | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-19-66 | |
| 23C. PHYSICIAN'S NAME (Type) Ronald D. Snyder | | 23D. ADDRESS Maryland General Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/21/66 | | 24C. NAME OF CEMETERY or CREMATORY Parkwood Cem. | |
| 24D. LOCATION (City, town, or county) Baltimore, Maryland | | (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 21 1966 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS Leonard J. Buck Inc. 5305 Harford Rd. #14 | |

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10-10-1960

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--|---|--|---|--|
| BIRTH NO. 66 12784 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12784 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Mrs Edith Wolf</i> | | 2. DATE AND HOUR OF DEATH <i>12/21/68 5:00 PM</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCY (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY | | M. | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>37 Mercy Hosp</i> | | (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 27-38</i> | |
| D. STREET ADDRESS (If rural, give location) <i>5704 Shu Alameda</i> | | 5. SEX <i>F</i> | | 6. RACE <i>W</i> | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>widowed</i> | | 8. DATE OF BIRTH <i>12-11-1896</i> | | 9. AGE (In years lost birthday) <i>70</i> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Substitute School Teacher</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 13. FATHER'S NAME <i>Matthew (Payle) Doyle</i> | | 14. MOTHER'S MAIDEN NAME <i>Isabelle C. Feehelly</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i> | | 16. SOCIAL SECURITY NO. <i>218342023</i> | | 17. INFORMANT <i>Mrs Isabelle C. Feehelly</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Ca of bladder</i> | | 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <i>neon</i> | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>none</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (<u>this hospital</u>) attended the deceased from <i>Nov 30</i> 19 <i>66</i> to <i>12/21</i> 19 <i>66</i> , that (I) (<u>we</u>) last saw the deceased alive on <i>12/21</i> 19 <i>66</i> and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>We</u>) (<u>did</u>) (<u>did not</u>) view the body after death. | | | | | |
| 23A. SIGNATURE <i>In Baegon</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>12/21/68</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Gerald Galvin</i> | | M.D. | | 23D. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i> | | 24B. DATE <i>12-24-66</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cem.</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 21 1966</i> | | | |
| 25B. NAME OF REGISTRAR <i>Robert E. ...</i> | | 25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc Baltimore, Md.</i> | | | |

(Type I)

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|---|--|--|---|--|--|--|--|--|---------------------------------|--|
| BIRTH NO. 66 12785 | | | | | REGISTERED NO. 66 12785 | | | | | |
| M.E. CASE NO. | | | | | CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED (Type or Print) G. Merrill Clemmer | | | | | 2. DATE AND HOUR OF DEATH December 19, 1966. 1:14 P.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 Johns Hopkins Hospital | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balto. Co. | | | | | |
| 5. SEX Male 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | | | | | 8. DATE OF BIRTH Sept. 21, 1905 9. AGE (In years last birthday) 61 | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter | | | | | 11. BIRTHPLACE (State or foreign country) Penna. | | | | | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 13. FATHER'S NAME Unknown | | | | | 14. MOTHER'S MAIDEN NAME Unknown Landis | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 2 | | | | | 16. SOCIAL SECURITY NO. 155-01-5189 | | | | | |
| 17. INFORMANT Mrs. Laura J. Clemmer | | | | | ADDRESS (Same) | | | | | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating, the UNDERLYING CONDITION last. Arteriosclerotic Cardiovascular Disease | | | | | CAUSE OF DEATH (A) Acute Myocardial Infarction (B) Arteriosclerotic Cardiovascular Disease (C) _____ | | | | | |
| 19. DATE OF OPERATION 0 | | | | | 20A. AUTOPSY? (Yes or No) No | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from MAY 12 19 66 to Dec 19 66 , that (I) (we) last saw the deceased alive on 6-28 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE Larry G. Tilley M.D. | | | | | 23B. DATE SIGNED 12-20-66 | | | | | |
| 23C. PHYSICIAN'S NAME (Type) Larry G. Tilley M.D. | | | | | 23D. ADDRESS 1713 Taylor Avenue | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 24B. DATE 12/22/66. | | 24C. NAME OF CEMETERY or CREMATORY Old Trinity Cemetery | | | 24D. LOCATION (City, town, or county) (State) Church Creek, Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 21 1966 | | | 25B. NAME OF REGISTRAR Robert E. Johnson | | | 25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. | | | ADDRESS Balto. Md. 21214 | |

Anti-Monarchical Republic
International Brotherhood
of Workers

May 12
1900

George A. Kelley

B-240

66 12786

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12786

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

THOMAS R. BOSLEY

2. DATE AND HOUR PRONOUNCED DEAD

December 16, 1966 6:50 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

7330 Harford Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

7330 Harford Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

2-13-40

9. AGE (In years
(last birthday)

26

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

ATTENDANT

10B. KIND OF BUSINESS OR INDUSTRY

SERVICE STATION

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Roy Millard Bosley

14. MOTHER'S MAIDEN NAME

MARGARET REBECCA MOSEBROOK

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

YES 4-1-57 2-7-58

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

CATHERINE Bosley 2218 WESTFIELD AVE.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Asphyxia by carbon monoxide
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

car in filling station 7330 Harford Road

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

12-16-66 ?

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Presumably asphyxiated
accidently by carbon monoxide

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

December 16, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

12-20-66

23C. NAME OF CEMETERY or CREMATORY

BALTO. NATIONAL

23D. LOCATION

(City, town, or county)

(State)

BALTIMORE, MARYLAND

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

DEC 22 1966

Robert E. Taylor

Nicholas T. MATTHEWS, 3021 EASTERN AVE.

| | | |
|--------------------|-----------------------------|----|
| ATTENDANT | 2-15-45 | 26 |
| ROY MILLARD BOSLEY | MARYLAND | |
| YES 4-1-47 2-7-47 | MARGARET REBECCA MURPHY | |
| | CATHERINE BOSLEY and WALTER | |

Journal

12-20-46 Baltimore National

Baltimore, Maryland

WILLIAM T. MATTHEWS and ELEANOR

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 12787 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12787 | |
|---|---------------------|--|------------------------------------|--|--|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | Registered No. | |
| 1. NAME OF DECEASED (Type or Print) Mr. LEO FELDSE | | | | 2. DATE AND HOUR OF DEATH Dec 18, 1966 7.35 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 49 Doctors Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore Md. 21212 D. STREET ADDRESS (If rural, give location) 302 Kerneway | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 7-26-91 | | 9. AGE (In years lost birthday) 75 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier | | 10B. KIND OF BUSINESS OR INDUSTRY Diamond Cab Co. | | 11. BIRTHPLACE (State or foreign country) Lancaster Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Louis Feldser | | | | 14. MOTHER'S MAIDEN NAME MARY Sulcove | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 213-12-6442 | | 17. INFORMANT M.S. Selma McNaughton, 320 Kerneway #12 | |
| 18. 42011 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial infarction few minutes. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. A.S.C.V. Disease in failure years. advanced and severe coronary artery disease Early gangrene rt. toes due to AS, few days. | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH few minutes. years. years | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Net While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1962 to Dec 18 19 66 , that (I) (we) last saw the deceased alive on Dec 18 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Ataollah Golpira M.D. | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED Dec 18, 1966 | |
| 23C. PHYSICIAN'S NAME (Type) ATAOLLAH GOLPIRA M.D. | | | | 23D. ADDRESS 1942 Cedar Lane, Baltimore, Md. 21222 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/20/66 | | 24C. NAME of CEMETERY or CREMATORY Baltimore Hebrew | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 22 1966 | | 25B. NAME OF REGISTRAR Robert E. Salzman | | 25C. FUNERAL DIRECTOR Sol Levinson & Bros. Inc., | | ADDRESS 6010 Reisterstown | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12788 | |
|---|-------------------------|---|---|--|---|
| BIRTH NO. 66 12788 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>Snyder, Rebecca</u> | | | 2. DATE AND HOUR OF DEATH <u>12-19-66</u> <u>6:30</u> P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>THE JOHNS HOPKINS HOSPITAL</u> <u>33</u> | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>28-03</u> D. STREET ADDRESS (If rural, give location) <u>4203 PRINCE GEORGE RD</u> | | |
| 5. SEX <u>FEMALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOW</u> | 8. DATE OF BIRTH <u>MM/DD/YYYY</u> | 9. AGE (In years last birthday) <u>78</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>At Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Poland</u> | |
| 13. FATHER'S NAME <u>SOLOMON WILKENS</u> | | | 14. MOTHER'S MAIDEN NAME <u>MARY KRAMER</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | | 17. INFORMANT <u>Mr. Solomon H. Snyder, 3108 Woodvalley Drive</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cerebral Vascular Accident 2 wks</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>None</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from <u>Dec. 5</u> 19 <u>66</u> to <u>Dec 19</u> , 19 <u>66</u> , that (1) (he) last saw the deceased alive on <u>Dec 19</u> , 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Andrew P. Weinfeis</u> M.O. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED <u>12-19-66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Andrew P. Weinfeis</u> | | 23D. ADDRESS <u>Johns Hopkins Hospital</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12/20/66</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Beth Tshoh</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 22 1966</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Salama</u> | | 25C. FUNERAL DIRECTOR <u>Sol Levinson & Bros. Inc., 6010 Reisterstown</u> | |

1947-48

1948-49

1949-50

1950-51

1951-52

1952-53

1953-54

1954-55

1955-56

1956-57

1957-58

1958-59

1959-60

1960-61

1961-62

1962-63

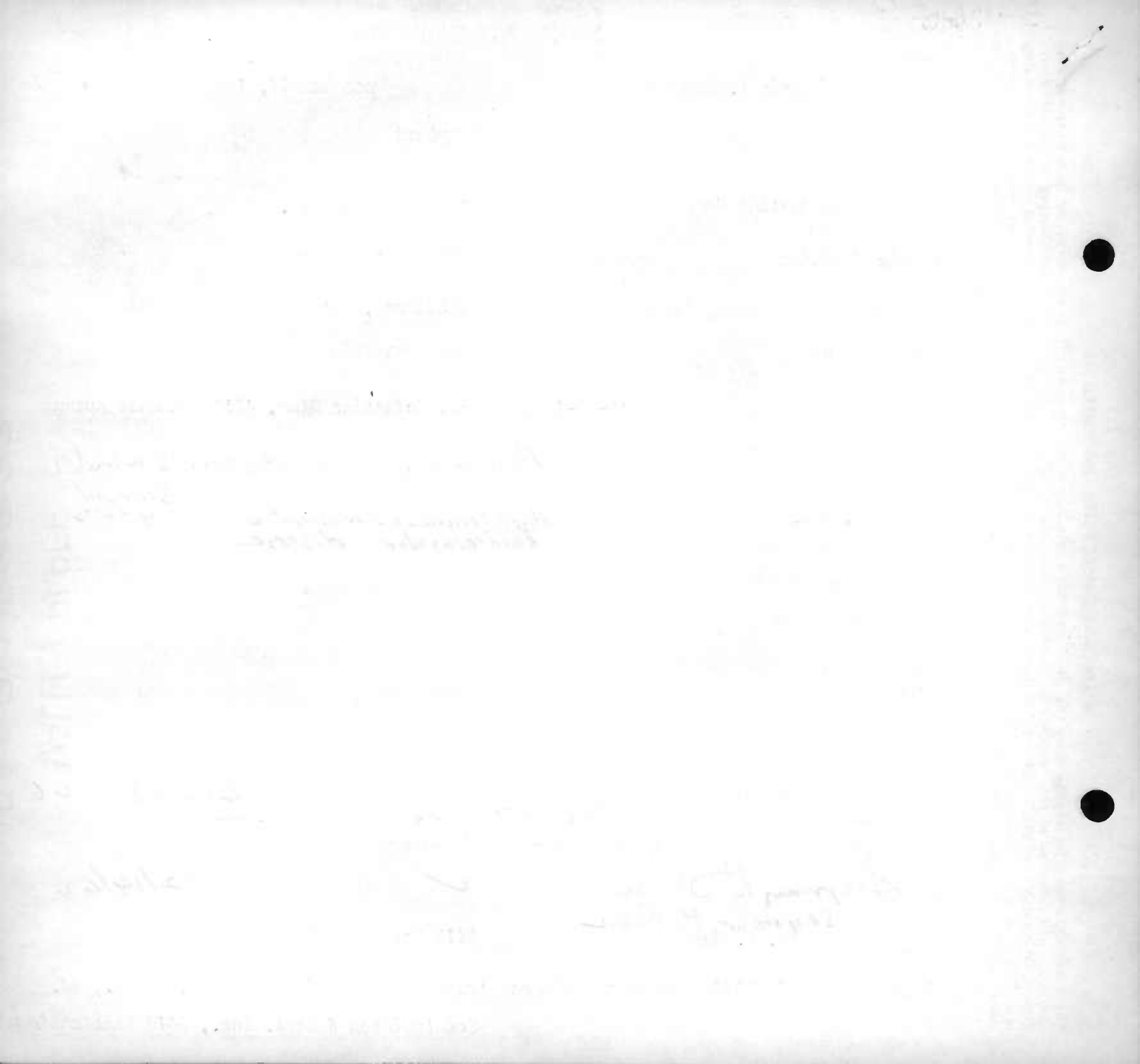
1963-64

1964-65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 12789</u> | |
|---|------------------------------|---|---|---|---|
| BIRTH NO. <u>66 12789</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Doris L. Shapiro</u> | | 2. DATE AND HOUR OF DEATH <u>December 18, 1966</u> <u>9:45 A.M.</u> | |
| 3. PLACE OF DEATH IN <u>BALTIMORE, MARYLAND</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>90 Friedler Nursing Home</u> | | (If not in hospital or institution, give street address or location) | | D. STREET ADDRESS (If rural, give location) <u>4716 Garrison Blvd.</u> | |
| 5. SEX <u>Female</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u> | 8. DATE OF BIRTH <u>1898</u> | 9. AGE (In years last birthday) <u>68</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>At Home</u> | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME <u>Solomon Blum</u> | | | 14. MOTHER'S MAIDEN NAME <u>Mary Margolia</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>217-20-1663</u> | 17. INFORMANT ADDRESS <u>Miss Katherine Blum, 4216 Penhurst Avenue</u> | | |
| 18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <u>Anter myocardial infarction</u> | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> <u>Several years</u> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1967</u> to <u>Dec 18</u> 19 <u>66</u> , that (I) (was) last saw the deceased alive on <u>Dec 17</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (the) (did) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Seymour H. Rubin</u> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>12/19/66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Seymour H. Rubin</u> <u>Dr. S. Rubin</u> | | 23D. ADDRESS M.D. <u>5415 Park Heights Avenue</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | 24B. DATE <u>12/20/66</u> | 24C. NAME OF CEMETERY or CREMATORY <u>Greater Baltimore Lodge</u> | | 24D. LOCATION (City, town, or county) (State) <u>Bowleys Lane, Balto., Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 22 1966</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>Sol Levinson & Bros. Inc., 6010 Reisterstown</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|---------------------------|--|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. <u>66 12790</u> | |
| 66 12790 | | 66 12790 | |
| 1. NAME OF DECEASED (Type or Print) <u>Rebecca Sandler</u> | | 2. DATE AND HOUR OF DEATH <u>12/19/66</u> <u>5:00 P.M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>42 Sinai Hospital</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Balt.</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>3918 Norfolk Ave</u> | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED NEVER MARRIED <u>WIDOWED</u> DIVORCED (specify) | 8. DATE OF BIRTH <u>[REDACTED]</u> |
| 9. AGE (In years lost birthday) <u>79</u> | | 10. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>At Home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Lithuania</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Isaac Eskowitz</u> | | 14. MOTHER'S MAIDEN NAME <u>DENA ?</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | |
| 17. INFORMANT <u>Mr. Herbert Sandler, 6605 Shelrick Place #9</u> | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>pneumonia</u> <u>pulmonary insuff</u> <u>ASHD</u> <u>chronic brain syndrome</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION <u>12-6-66</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>fx. D femur</u> | |
| 20A. AUTOPSY? (Yes or No) <u>no</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>nursing home</u> | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>Milford Manor Nursing Home</u> | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>12-5-66</u> | |
| 21E. INJURY OCCURRED <u>While At Work</u> <input type="checkbox"/> <u>Not While At Work</u> <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? <u>fell out of bed</u> | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12-5-1966</u> to <u>12-19-1966</u> , that (I) (we) last saw the deceased alive on <u>12-19-1966</u> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above <u>(I) (We) (did) (did not)</u> view the body after death. | | | |
| 23A. SIGNATURE <u>L. J. Moglen</u> M.D. | | 23B. DATE SIGNED <u>12/19/66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>L. J. Moglen</u> M.D. | | 23D. ADDRESS <u>Sinai Hosp</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | 24B. DATE <u>12/20/66</u> | 24C. NAME OF CEMETERY or CREMATORY <u>Beth Tshilo</u> | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 22 1966</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Sandler</u> | |
| 25C. FUNERAL DIRECTOR <u>Sol Levinson & Bros. Inc., 6010 Reisterstown</u> | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 12791</u> | |
|--|---------------------|---|------------------------------------|---|--|
| BIRTH NO. <u>66 12791</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>IRENE BLOOM</u> | | 2. DATE AND HOUR OF DEATH <u>12-17-66</u> <u>12:25</u> P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>LUTHERAN HOSPITAL OF MARYLAND</u> | | A. STATE <u>Maxine St.</u> B. COUNTY <u>Howard Co., Md.</u> | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Ellicott City, Md.</u> | | | |
| | | D. STREET ADDRESS (If rural, give location) <u>Maxine Street</u> | | | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED <u>WIDOWED, DIVORCED</u> (specify) | 8. DATE OF BIRTH <u>9/16/88</u> | 9. AGE (In years last birthday) <u>78</u> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Own home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | 13. FATHER'S NAME <u>William H. Harding</u> | | 14. MOTHER'S MAIDEN NAME <u>Emma James</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>212-48-2328 D</u> | | 17. INFORMANT ADDRESS <u>ELICOTT CITY, MD.</u> <u>JAMES O. BLOOM MAXINE ST.</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>602X I</u> | | CAUSE OF DEATH (A) <u>Peritonitis</u> DUE TO (B) <u>Peri-Renal Abscess</u> DUE TO (C) <u>Stag-Horn Calculus @ kidney</u> | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | <u>Congestive Heart failure & Pneumonia</u> | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Expt. Left Kidney</u> | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>11-27</u> 19 <u>66</u> to <u>12-17</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12-17</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Edward Stinson</u> | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) <u>EDWARD STINSON</u> M.D. | | | | 23D. ADDRESS <u>730 Ashburton St. Balt., Md.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12/20/66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>St. Johns Cemetery</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Ellicott City, Maryland</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 22 1966</u> | | | |
| 25B. NAME OF REGISTRAR <u>Robert E. Jackson</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>Easton Funeral Home Catonsville Md</u> | | | |

Part of a specimen - 11/5/9 - address not in hand

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 12792 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 66 12792 | | | | | |
|--|--|-----------------------|--|--|--|--|--|--|---|--|--|---------------------|--|
| 1. NAME OF DECEASED (Type or Print) IRENE BRITT | | | | 2. DATE AND HOUR OF DEATH 12-17-66 10.45 P.M. | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL 33 | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 27-34 D. STREET ADDRESS (If rural, give location) 6116 EVERALL AVE 21206 | | | | | | | | | |
| 5. SEX FEMALE | | 6. RACE WHITE | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) DIVORCED | | 8. DATE OF BIRTH 1-19-20 | | 9. AGE (In years, lost birthday) 48 | | If Under 1 Yr. Months Days Hours Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MD. | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME JAMES GILLESBIE | | | | | | 14. MOTHER'S MAIDEN NAME MAUDE POWELL | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. 218-03-3117 | | 17. INFORMANT J.B. GILLESBIE | | | | ADDRESS 6116 EVERALL AVE. | | | |
| 18. CAUSE OF DEATH | | | | | | | | | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | (A) Mitral Valve Replacement DUE TO | | | INTERVAL BETWEEN ONSET AND DEATH 1 day | | | | |
| | | | | | | (B) Mitral Stenosis DUE TO | | | 10 yrs | | | | |
| | | | | | | (C) Rheumatic Heart Disease | | | 30+ yrs | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION 12/16/66 & 12/17/66 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Mitral Stenosis | | | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) Dec. 17 1966 10:40 PM | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (this hospital) attended the deceased from Dec 13 1966 to Dec 17 1966, that (we) last saw the deceased alive on Dec 17, 1966 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 23A. SIGNATURE Arthur C. Burdett | | | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/17/66 | | | |
| 23C. PHYSICIAN'S NAME (Type) ARTHUR C. BURDETT | | | | | | | | 23D. ADDRESS M.D. THE JOHNS HOPKINS HOSPITAL | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12/20/66 | | 24C. NAME OF CEMETERY or CREMATORY SACRED HEART | | | | 24D. LOCATION (City, town, or county) (State) BALTO. MD | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 22 1966 | | | | 25B. NAME OF REGISTRAR R. E. Taylor | | | | 25C. FUNERAL DIRECTOR J. G. CONNELLY SONS | | | | ADDRESS 300 MACE | |

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Handwritten text, possibly a date or location, appearing in the middle right section.

Handwritten text, possibly a date or location, appearing in the lower right section.

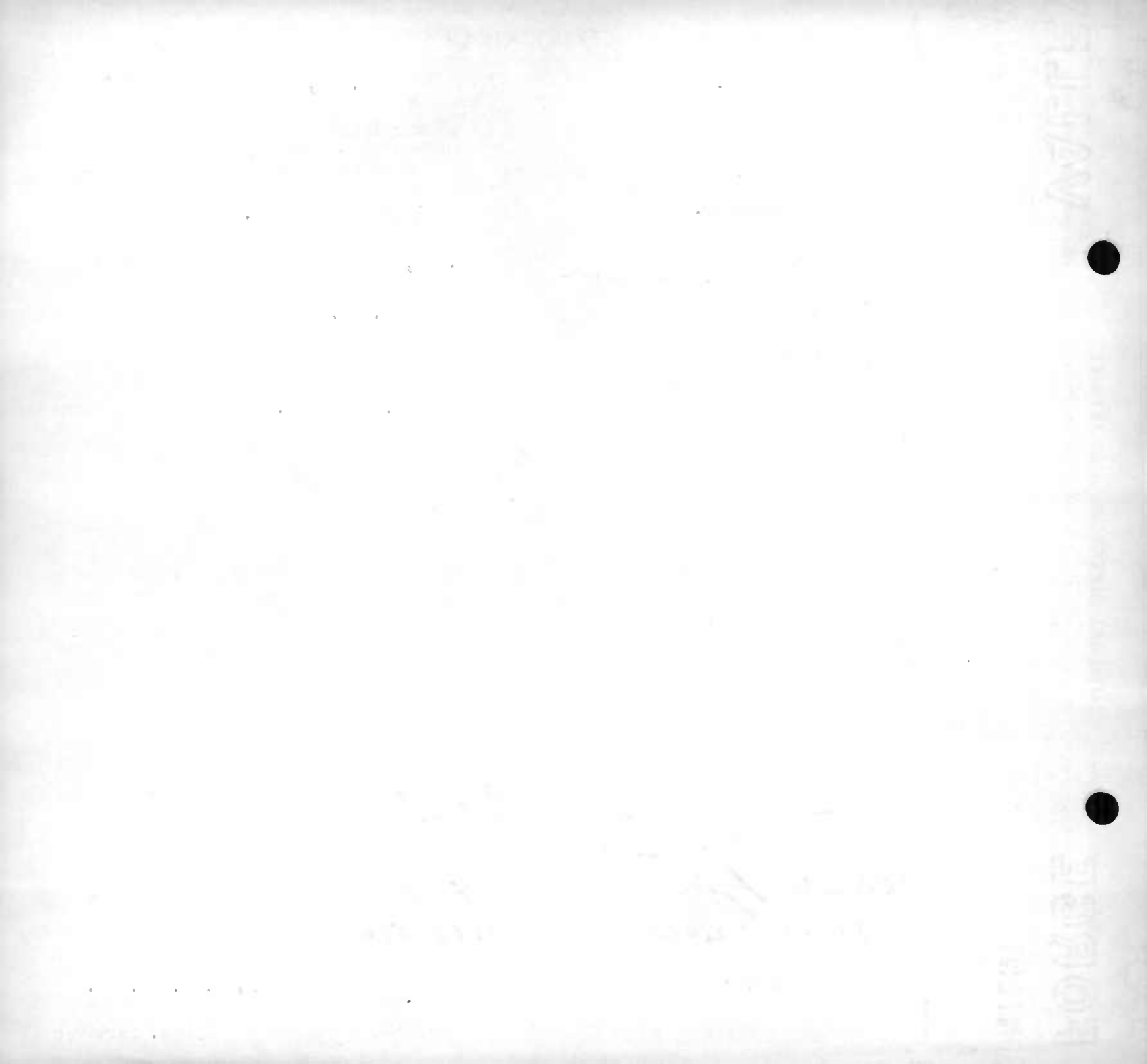
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X

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 12793</u> | |
|---|-------------------------|--|--|---|---|
| BIRTH NO. <u>66 12793</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Selda C. Hicks</u> | | 2. DATE AND HOUR OF DEATH <u>Dec. 19, 1966</u> <u>7⁰⁰ A.M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY | | C. CITY OR TOWN (If outside city limits, write RURAL and give town) <u>Baltimore</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>00</u> <u>1719 Clarkson St.</u> | | (If not in hospital or institution, give street address or location) | | D. STREET ADDRESS (If rural, give location) <u>1719 Clarkson St.</u> | |
| 5. SEX <u>Female</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widow</u> | 8. DATE OF BIRTH <u>Jan. 21, 1900</u> | 9. AGE (In years last birthday) <u>66</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>At Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U S A</u> | | 13. FATHER'S NAME <u>Joseph Stencil</u> | | 14. MOTHER'S MAIDEN NAME <u>Loretta Unknown</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>William L. Hicks Jr.</u> | |
| 18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial infarction</u> <u>Anteroseptal Heart Disease</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH <u>Same</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>August</u> 19 <u>66</u> to <u>Dec. 18</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>December 16</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Ricardo Lozada</u> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>12/19/66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>RICARDO LOZADA</u> | | 23D. ADDRESS M.D. <u>1228 S. Charles St. Balt. Md 21230</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12 21 66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Cedar Hill</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Brooklyn, A. A. Co. Md.</u> | | 25A. DATE REC'D. BY HEALTH DEPT. <u>DEC 22 1966</u> | | | |
| 25B. NAME OF REGISTRAR <u>P. E. E. F. E. E.</u> | | 25C. FUNERAL DIRECTOR <u>Mc Cully</u> | | | |
| ADDRESS <u>130 E. Fort Ave</u> | | | | | |



D-325

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|------------------|--|--|--|--|---|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12794 | | | | | | | | | |
| BIRTH NO. 66 12794 | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) ROY E. DOTSON | | | | | 2. DATE AND HOUR PRONOUNCED DEAD December 16, 1966 11:35 P.M. | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 St. Agnes Hospital | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Carroll C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sykesville - Rural - Westminster D. STREET ADDRESS (If rural, give location) RFD # 6 56-00 | | | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH Nov. 4, 1937 | 9. AGE (In years last birthday) 29 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Agent | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Carroll Co., Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Roy E. Dotson | | | | | 14. MOTHER'S MAIDEN NAME Harriet Randall | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes Jan. 1961 to Mar. 1962 | | | 16. SOCIAL SECURITY NO. 218-32-6210 | | 17. INFORMANT ADDRESS Rt. 144 Cooksville, Md. Mrs. Josephine H. Dotson | | | | |
| 18. CAUSE OF DEATH | | | | | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) (A) Crushed Chest. DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Rt. 40 and Rt. 99, Howard Co. 63-00 | | | | | |
| 21D. TIME OF INJURY (APPROX.) 12 16 '66 P | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? Driver in auto-truck collision. | | | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Petty | | M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | DATE SIGNED 12/17/66 | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 12/20/1966 | | 23C. NAME of CEMETERY or CREMATORY Fairview Cemetery | | 23D. LOCATION (City, town, or county) (State) Carroll Co., Md. | | | |
| 24A. DATE REC'D BY HEALTH DEPT. DEC 22 1966 | | 24B. NAME OF REGISTRAR Robert E. Feltner | | 24C. FUNERAL DIRECTOR ADDRESS C. M. Waltz Box 241 Sykesville, Md. | | | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|---|---------|--|------------------|--|-----------------------------|
| 66 12795 | | CERTIFICATE OF DEATH | | 66 12795 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| | | FRANCES M. PISARSKI | | 12-20-66 10:30 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | A. STATE B. COUNTY | | | |
| Mercy Hospital | | Md. | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | Balto 1-02 | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 3024 E. Pratt St | | | |
| 5. SEX | 6. RACE | 7. MARRIED NEVER MARRIED WIDOWED DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months Days |
| F | W | M. | 11-23-12 | 54 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| | | BAKERY | | MARYLAND | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| FRANK BERNADZIKOWSKI | | MARY RUSIN | | USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| No | | 212-16-8167 | | LOUIS PISARSKI 3024 E. PRATT ST. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | | 5+ yrs | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 12-18-66 | | Biopsy of liver metast. | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-9-66 to 12-20-66, that (I) (we) last saw the deceased alive on 12-20-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Hung-jen Fu | | | | 12-21-66 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Hung-jen Fu | | MERCY HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| BURIAL | | 12-24-66 | | HOLY ROSARY CEM | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| DEC 22 1966 | | John M. Webert | | JOHN M. WEBERT & SONS INC. 401 S. CHESTER ST. | |
| | | | | 24D. LOCATION (City, town, or county) (State) | |
| | | | | DUNDALK MARYLAND | |

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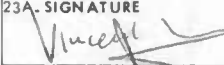
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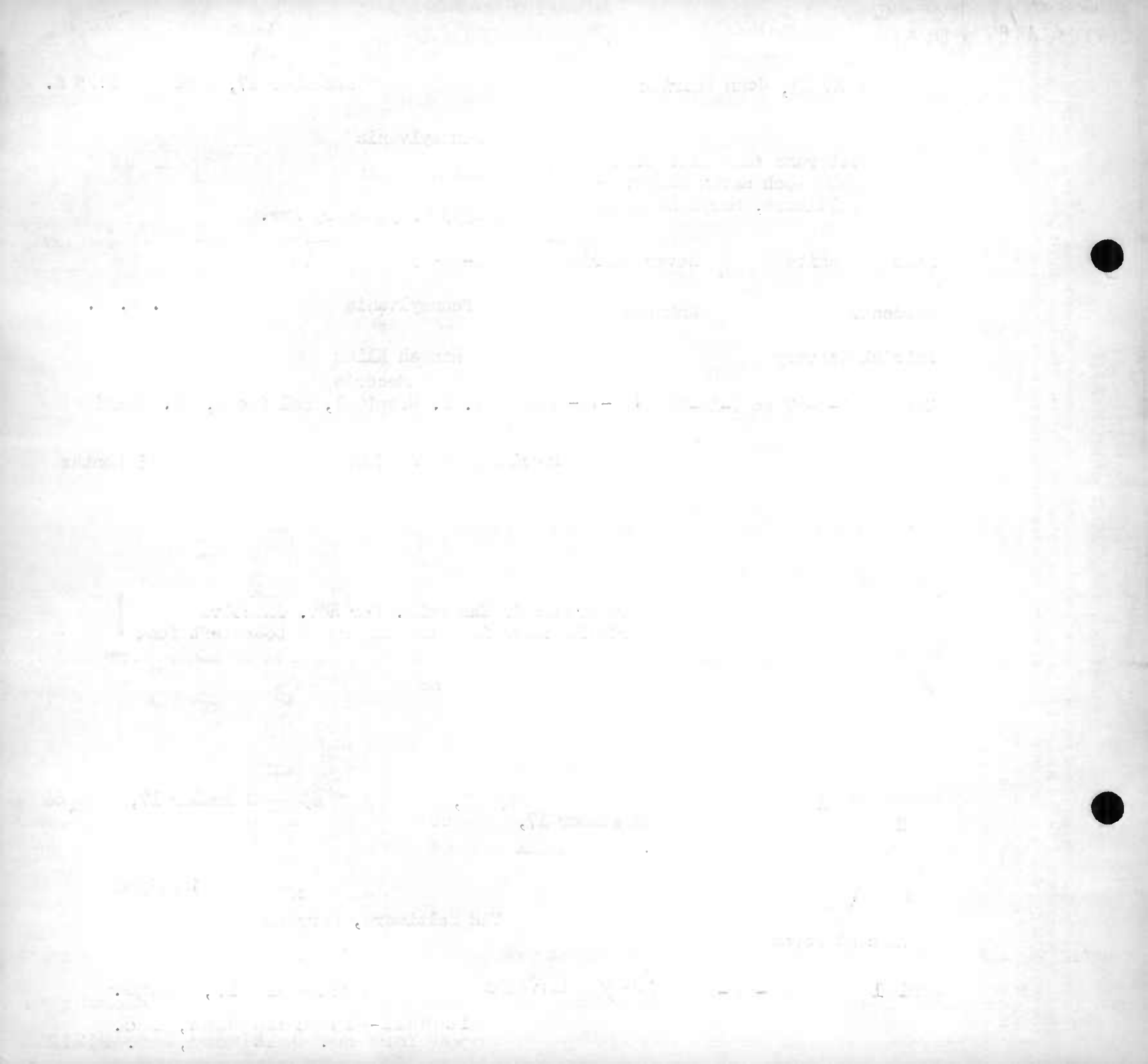
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|--|------------------------------|---|--|--|--|
| BIRTH NO. 66 12796 | | CERTIFICATE OF DEATH | | 66 12796 | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) CONVERY, John Patrick | | | December 17, 1966 6:25 A. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 27 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218 | | | A. STATE Pennsylvania B. COUNTY Philadelphia C. CITY OR TOWN (If outside city limits, write RURAL and give township) V-35 D. STREET ADDRESS (If rural, give location) 2535 Grays Ferry Ave. | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never Married | 8. DATE OF BIRTH 6-20-95 | 9. AGE (In years last birthday) 71 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardener | | 10B. KIND OF BUSINESS OR INDUSTRY Unknown | 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. |
| 13. FATHER'S NAME Patrick Convery | | | 14. MOTHER'S MAIDEN NAME Hannah Klien | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 4-7-17 to 9-13-18 | | 16. SOCIAL SECURITY NO. 199-18-6545 | 17. INFORMANT Records V. A. Hospital, Baltimore, Md. 21218 | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Carcinoma of the lung | | | INTERVAL BETWEEN ONSET AND DEATH 19 Months | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Tuberculosis XXX Pulm. far adv. Inactive Arteriosclerosis with Gangrene of toes left foot | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 27, 1965 to December 17, 1966 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on December 17, 1966 and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) XXXX view the body after death. | | | | | |
| 23A. SIGNATURE  Vincent Lopez | | | 23B. DATE SIGNED 12/18/66 | | |
| 23C. PHYSICIAN'S NAME (Type) Vincent Lopez | | | 23D. ADDRESS VAN Baltimore, Maryland | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 12-20-66 | 24C. NAME OF CEMETERY or CREMATORY HOLY CROSS | 24D. LOCATION (City, town, or county) (State) Philadelphia, Penna. | | |
| 25A. DATE RECEIVED BY HEALTH DEPT. DEC 22 1966 | | 25B. NAME OF REGISTRAR Robert E. Jenkins | 25C. FUNERAL DIRECTOR ADDRESS Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, Md. 21212 | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. 66 12797 | | CERTIFICATE OF DEATH | | Registered No. 66 12797 | |
|--|--|--|--|---|--|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) MARY AGNES WALSH | | | | 2. DATE AND HOUR OF DEATH 12/16/66 8:00 A.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 001549 Northbourne Road | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-09 D. STREET ADDRESS (If rural, give location) 1549 Northbourne Road | | | | | |
| 5. SEX Female | | 6. RACE White | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | | 8. DATE OF BIRTH 1880 | | 9. AGE (In years last birthday) 86 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | | | 10B. KIND OF BUSINESS OR INDUSTRY --- | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Hanley | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | | | 16. SOCIAL SECURITY NO. --- | | 17. INFORMANT Rev. Eugene A. Walsh (Son) | | | |
| 18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) Myocardial Infarction DUE TO Immediate (B) Arteriosclerotic Cardio-Vascular Disease DUE TO 5 yrs. (C) _____ | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from May 1 19 61 to December 16 19 66 , that (I) (we) last saw the deceased alive on December 1 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Philip D. Flynn | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 12/16/66 | | | |
| 23C. PHYSICIAN'S NAME (Type) Philip D. Flynn | | 23D. ADDRESS M.D. 11 East Chase St. | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/19/66 | | 24C. NAME OF CEMETERY or CREMATORY Cathedral Cem. | | 24D. LOCATION (City, town, or county) (State) Balto. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 22 1966 | | 25B. NAME OF REGISTRAR Philip E. Sady | | 25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc. | | ADDRESS 6500 York Road-21212 | | | |

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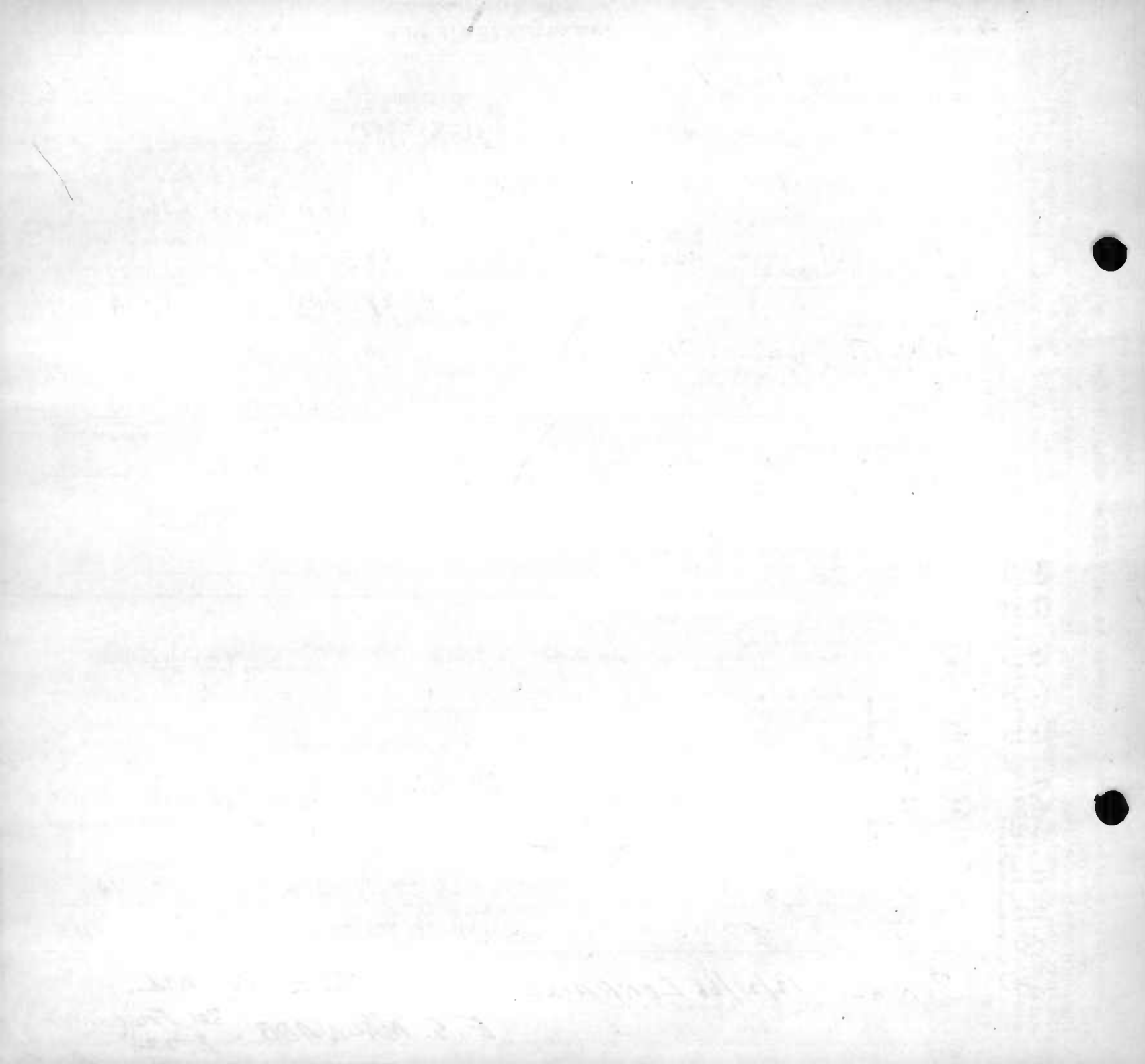
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|--|-------------------------|---|-------------------------------------|--|--|
| BIRTH NO. M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) FREDERICK J. C. KNUDSON | | 2. DATE AND HOUR PRONOUNCED DEAD December 19, 1966 1:30 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 00 1412 S. Hanover Street | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 23-01 | | | |
| | | D. STREET ADDRESS (If rural, give location) 1412 S. Hanover Street | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED | 8. DATE OF BIRTH 7-3-1901 | 9. AGE (In years last birthday) 65 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER - (Act) | | 10B. KIND OF BUSINESS OR INDUSTRY SHIP YARDS - | | 11. BIRTHPLACE (State or foreign country) New Jersey | |
| 13. FATHER'S NAME P | | 14. MOTHER'S MAIDEN NAME P | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Unknown | | 16. SOCIAL SECURITY NO. (220-07-1672A) | | 17. INFORMANT MRS. FANNY M. CLARKSON ST. ADDRESS 1319 CLARKSON ST. BALTO. MD - 21230 | |
| 18. 443X | | CAUSE OF DEATH PHONE 3A-7-3237 | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) Hypertensive cardiovascular disease DUE TO | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) _____ DUE TO | | | |
| | | (C) _____ | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE Charles S. Springate | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED December 19, 1966 | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 23B. DATE Dec. 21-1966 | | 23C. NAME OF CEMETERY or CREMATORY ST. PAULS - 5th & E. Ce m | |
| | | 23D. LOCATION (City, town, or county) (State) BALTO MD. | | | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR Robert E. Taylor | | 24C. FUNERAL DIRECTOR CURTIS E. EVANS ADDRESS 14005 CHARLES ST 21230 | |

CURTIS E. EVANS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|---------------------|--|--------------------------------------|--|---|--|--|--|--|
| BIRTH NO. 66 12799 | | | | | CERTIFICATE OF DEATH | | | | |
| M.E. CASE NO. | | | | | Registered No. 66 12799 | | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Florence V Faringer</i> | | | | | 2. DATE AND HOUR OF DEATH <i>12-18-1966 7:30 P.M.</i> | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>NORTH CHARLES GENERAL HOSPITAL</i> <i>49</i> | | | | | A. STATE <i>MARYLAND</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> STREET ADDRESS (If rural, give location) <i>1001 Maiden Choice Lane</i> | | | | |
| 5. SEX <i>F</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>widow</i> | 8. DATE OF BIRTH <i>3-15-1883</i> | 9. AGE (In years last birthday) <i>83</i> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i> | | |
| 13. FATHER'S NAME <i>Wm. T. Dougherty GROVES</i> | | | | | 14. MOTHER'S MAIDEN NAME <i>Dougherty</i> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i> | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Sophia Froehlich</i> | | ADDRESS <i>Baltimore</i> <i>1001 Maiden Choice Lane</i> | | |
| 18. <i>420.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | | | CAUSE OF DEATH (A) <i>Acute heart failure</i> DUE TO (B) <i>Arteriosclerotic heart disease</i> DUE TO (C) | | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that he (this hospital) attended the deceased from <i>12-18</i> 19 <i>66</i> to <i>12-18</i> 19 <i>66</i> , that (I) was last saw the deceased alive on <i>12-18</i> 19 <i>66</i> and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <i>Neurology</i> | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>12-18-1966</i> | | |
| 23C. PHYSICIAN'S NAME (Type) <i>HAROLD H. Bix</i> | | | | | 23D. ADDRESS M.D. <i>1401 Reisterstown Rd Baltimore M.D.</i> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 24B. DATE <i>12/21/66</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>LORRAINE</i> | | 24D. LOCATION (City, town, or county) (State) <i>BALTO CO MD.</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 22 1966</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Johnson</i> | | 25C. FUNERAL DIRECTOR <i>F.S. MACNABB</i> | | ADDRESS <i>301 FREDERICK</i> <i>21228</i> | | | |

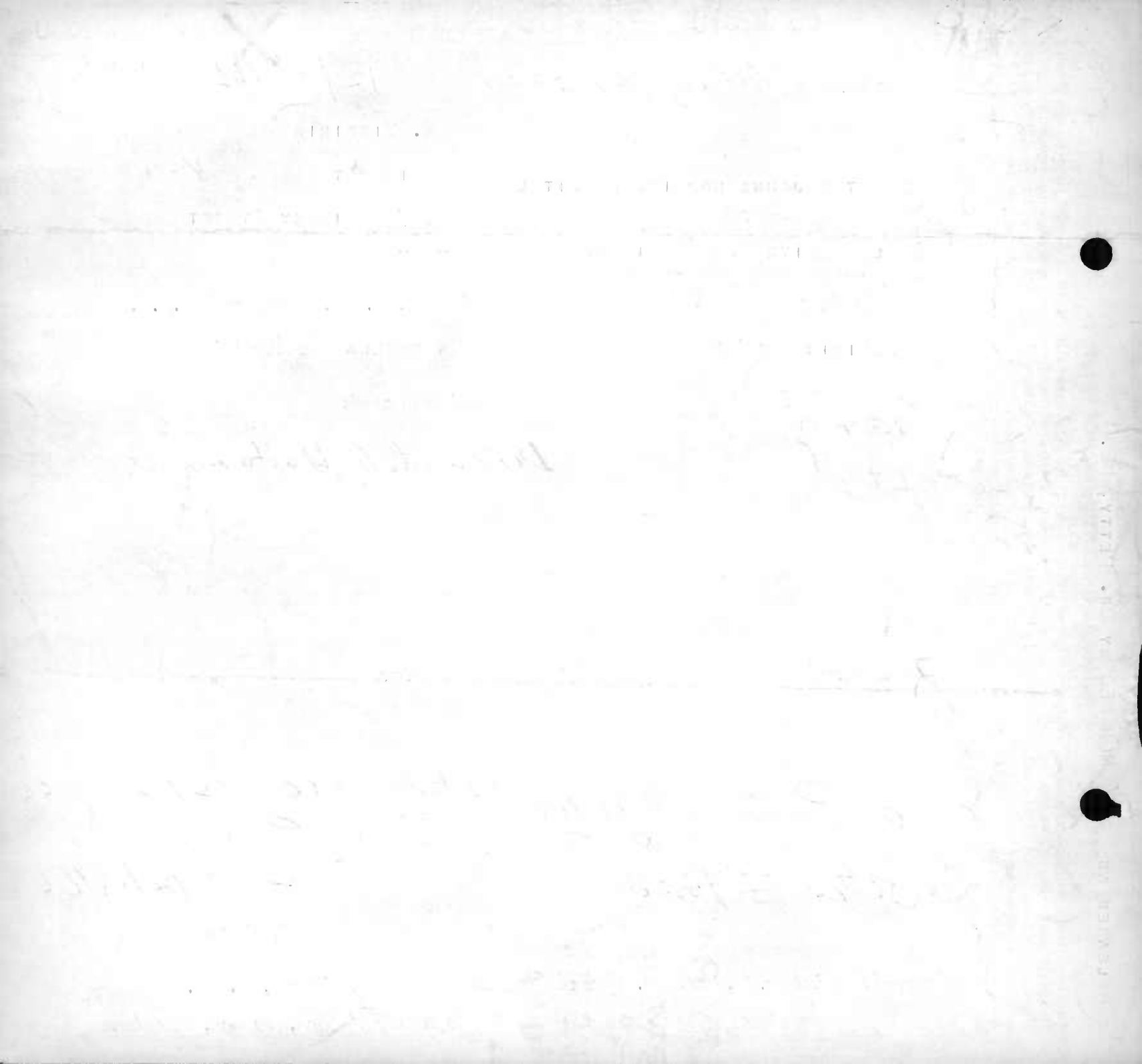


RELEASED AS

NON MED BY DR. PETTY, ME
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 12800 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 66 12800 | |
|---|--|--|--|---|--|--|--|---|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) <i>Romano, Anthony #1223761</i> | | 2. DATE AND/HOUR OF DEATH <i>12/18/66 11⁴⁵ a.</i> | | M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>W. VIRGINIA</i> B. COUNTY | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>FAIRMONT</i> | | D. STREET ADDRESS (If rural, give location) <i>207 McKINNEY STREET</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>33 THE JOHNS HOPKINS HOSPITAL</i> | | | | (If not in hospital or institution, give street address or location) | | 5. SEX <i>MALE</i> | | 6. RACE <i>WHITE</i> | |
| 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>WIDOWER</i> | | | | 8. DATE OF BIRTH <i>11-26-01</i> | | 9. AGE (In years last birthday) <i>65</i> | | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cement Contractor</i> | | | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Self Employed</i> | | 11. BIRTHPLACE (State or foreign country) <i>Fairmont, W. Va.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>DOMINIC Romino</i> | | | | 14. MOTHER'S MAIDEN NAME <i>CA RMELLA Delligatti</i> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes WW I</i> | | | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT <i>Family Records</i> | | ADDRESS | | | |
| 18. <i>134.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) <i>Disseminated Blastomycosis</i> DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | 19A. DATE OF OPERATION <i>12-18-66</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>YES</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from <i>12/12</i> 19 <i>66</i> to <i>12/18</i> 19 <i>66</i> , that (1) (we) last saw the deceased alive on <i>12/18</i> 19 <i>66</i> and that in (our) apinian death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | 23A. SIGNATURE <i>Peter J. Rose</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>12/18/66</i> | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Removal/Burial</i> | | | | 24B. DATE <i>Dec. 19, 1966</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Mt. Carmel Cemetery</i> | | 24D. LOCATION (City, town, or county) (State) <i>Fairmont, W. Va.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 22 1966</i> | | | | 25B. NAME OF REGISTRAR <i>R. E. F. Adams</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>John Burns' Sons, Towson, Maryland</i> | | | |



| BIRTH NO. <i>Pa. Geo. Co. Md</i> | | BALTIMORE CITY HEALTH DEPARTMENT | | 66 12801 | |
|---|---------|---|------------------|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | Registered No. <i>66 12801</i> | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR PRONOUNCED DEAD | |
| | | SCOTT REYNOLDS | | December 18, 1966 5:10 P. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) D. STREET ADDRESS (If rural, give location) | | | |
| City Hospital (DOA) | | Maryland Baltimore, C. North Essex 43 B. West Way | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| Male | White | | Dec. 6, 1964 | 2 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| never worked | | | | Baltimore, Maryland | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Jerry Reynolds | | Sara Marie Wantz | | U.S.A. | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| no | | none | | 730 Milford Mill Rd Mr. Russell Wantz Pikesville 8, Md | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH Acute bronchitis and bronchiolitis (A) DUE TO Bronchiditis with early bronchopneumonia | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST, | | (B) DUE TO | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (C) DUE TO | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 2 | | | | Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE | | Charles S. Springate, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | Charles S. Springate, M.D. | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | | 23C. NAME of CEMETERY or CREMATORY | |
| Burial | | 12/20/66 | | Lakeview Memorial | |
| 23D. LOCATION (City, town, or county) (State) | | 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | |
| Liberty Rd. Carroll Co. Md. | | DEC 22 1966 | | Robert E. Feltman | |
| 24C. FUNERAL DIRECTOR | | 24D. ADDRESS | | 24E. ADDRESS | |
| Loring Byers 8728 Liberty Rd. Md. | | Randallstown, | | | |

Letter from M.E. Office

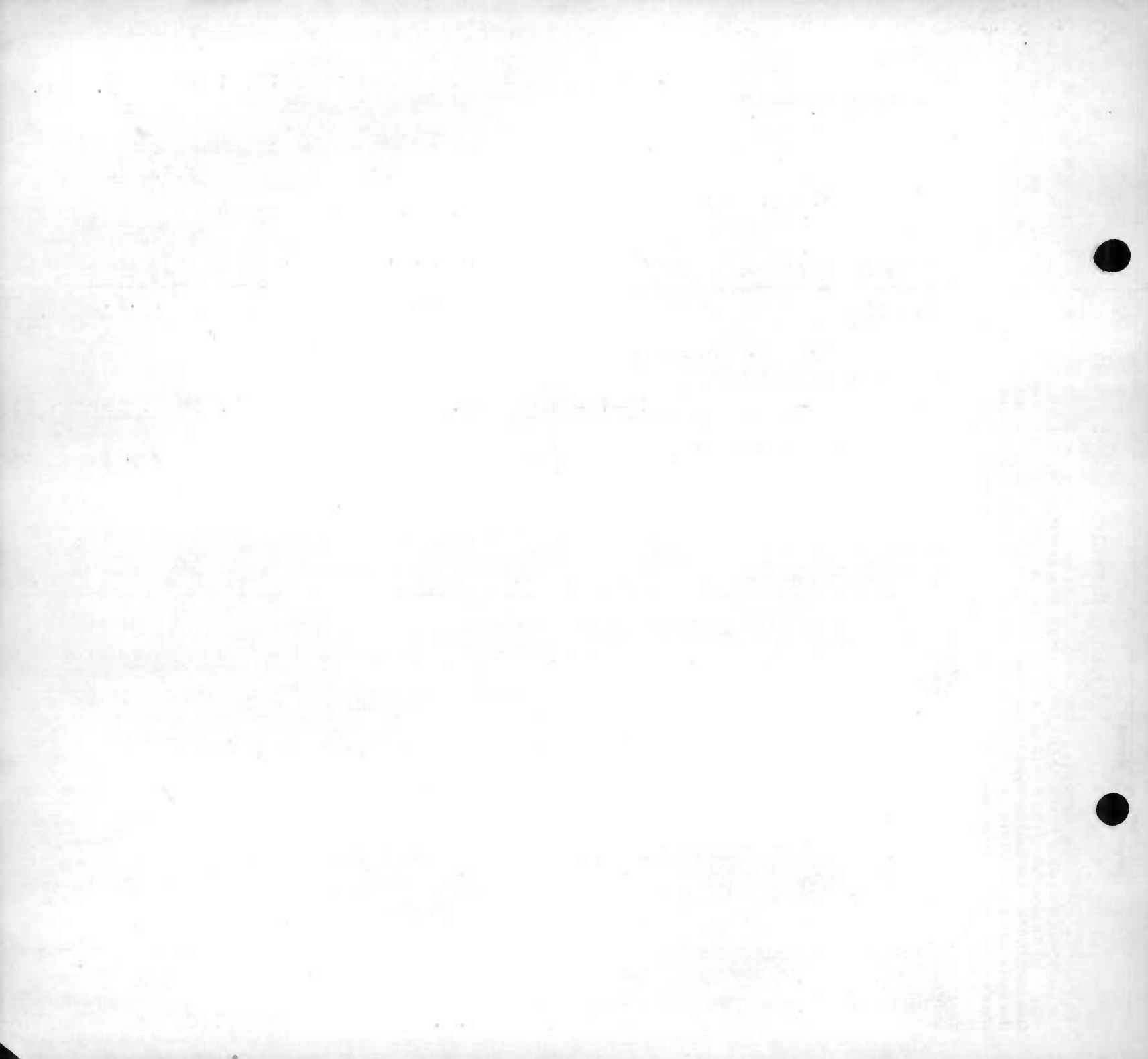
2-6-67

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

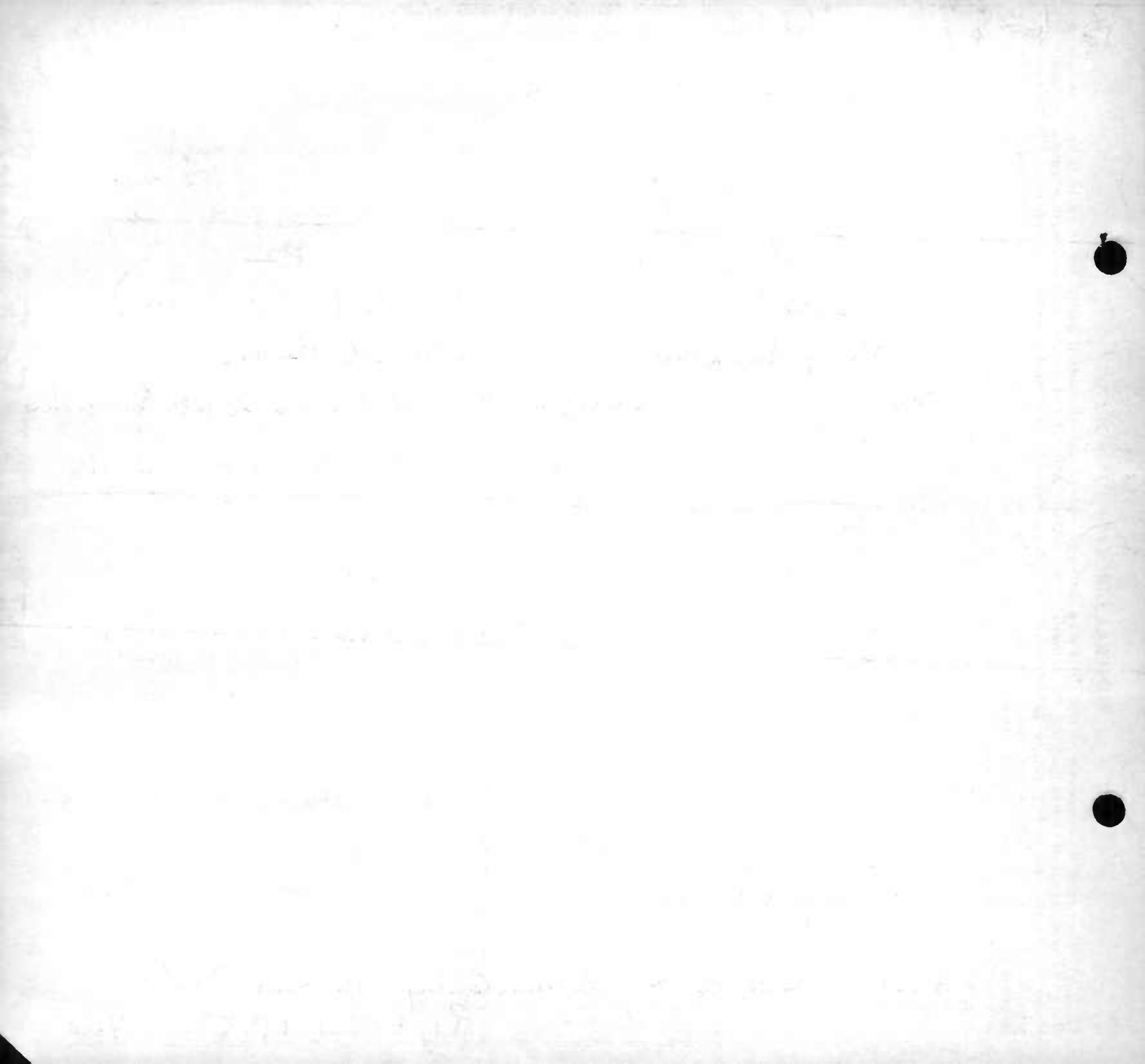
| | | | | | |
|---|---------|--|--------------------------|---|--|
| BIRTH NO. 66 12802 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 12802 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | JOSEPH J. CHRONOWSKI | | December 19, 1966 7.20 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | |
| 00 516 S. Durham Street | | Maryland | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| | | | | Baltimore 2-03 | |
| | | 516 S. Durham Street | | D. STREET ADDRESS (If rural, give location) | |
| | | | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |
| Male | White | Married | 7/23/1915 | 51 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
| Millwright | | Bethlehem Steel | | Maryland | U.S.A. |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| Joseph J. Chronowski | | | Maryanna Ciesla | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No - | | 212-10-2120 | | Mrs. Sophia Chronowski, 516 S. Durham St | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH | |
| | | | | Esophageal Carcinoma | |
| | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | 1 yr | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Oct 64</u> 19 <u>64</u> to <u>12-19-66</u> that (I) (we) last saw the deceased alive on <u>12-19-66</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Theodore T. Niznik M.D. | | | | 12-20-66 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| T. NIZNIK M.D. | | 429 S. Chester St 21231 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 12/23/66 | | Holy Rosary | |
| | | | | 24D. LOCATION (City, town or county) (State) | |
| | | | | Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| DEC 22 1966 | | Robert E. Falcetta | | M.F. SADOWSKI & SONS, 1808 EASTERN AVE | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------------|--|-----------------------------------|--|---|
| BIRTH NO. 66 12803 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12803 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Augusta Brockmeyer</i> | | 2. DATE AND HOUR OF DEATH <i>12-18-66</i> <i>7:55 P.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence, before admission) A. STATE <i>Md.</i> B. COUNTY <i>Balt. Co.</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>42 Sinai Hosp.</i> | | (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balto</i> <i>33-00</i> | |
| D. STREET ADDRESS (If rural, give location) <i>1014 Sumter Ave</i> | | | | | |
| 5. SEX <i>F</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>W</i> | 8. DATE OF BIRTH <i>9-8-84</i> | 9. AGE (In years last birthday) <i>82</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA.</i> | | 13. FATHER'S NAME <i>Henry Amerikhn</i> | | 14. MOTHER'S MAIDEN NAME <i>Elizabeth Beckner</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i> | | 16. SOCIAL SECURITY NO. <i>214 0163850</i> | | 17. INFORMANT <i>Richard Brockmeyer</i> | |
| ADDRESS <i>1036 Sumter Ave</i> | | | | | |
| 18. <i>156.11</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | CAUSE OF DEATH (A) <i>Carcinoma of the Liver</i> DUE TO (B) _____ DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH <i>2 wks.</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Hypertensive ASCVD</i> | | | | <i>10 yrs.</i> | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notly medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>12-18</i> <i>1966</i> to <i>12-18</i> <i>1966</i> , that (I) (we) last saw the deceased alive on <i>12-18</i> <i>1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Laurence Solomon</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>12-18-66</i> | |
| 23C. PHYSICIAN'S NAME (Type) | | M.D. | | 23D. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>Dec 22, 1966</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Holy Redeemer Cemetery</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 22 1966</i> | | 25B. NAME OF REGISTRAR <i>R. B. E. F. F. F.</i> | | 25C. FUNERAL DIRECTOR <i>Philip F. G. G.</i> | |
| ADDRESS <i>1211 Chesebrough Ave.</i> | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed at final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 12804</u> | |
|---|-------------------------|---|-----------------------------------|--|--|
| BIRTH NO. <u>66 12804</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>MILDRED JENKINS</u> | | 2. DATE AND HOUR OF DEATH <u>12/17/66</u> <u>7:15 A.</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>33 THE JOHNS HOPKINS HOSPITAL</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> | | | |
| | | D. STREET ADDRESS (If rural, give location) <u>819 S. ROBINSON STREET #21224</u> | | | |
| 5. SEX <u>FEMALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOW</u> | 8. DATE OF BIRTH <u>8-5-19</u> | 9. AGE (In years last birthday) <u>47</u> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WORK</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u> | | 11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>WILLIAM HILKER</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>ANNIE JONES</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | | |
| 16. SOCIAL SECURITY NO. <u>218-09-6873</u> | | 17. INFORMANT <u>HILDA M. HILKER 6217 DAVILLE AVE. BALTO. 24, MD.</u> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Epidermoid Carcinoma of cervix 1C III</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u> | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Diabetes mellitus</u> | | | | | |
| 21A. DATE OF OPERATION | | 21B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21C. AUTOPSY? (Yes or No) <u>Yes</u> | |
| 21D. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21E. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21F. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21G. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21H. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21I. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) <u>this hospital</u> attended the deceased from <u>MAY</u> 19 <u>66</u> to <u>Dec</u> 19 <u>66</u> , that (I) <u>we</u> lost saw the deceased alive on <u>Dec 17</u> 19 <u>66</u> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Donald B. Spangler</u> | | | | 23B. DATE SIGNED <u>Dec 17, 1966</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>DONALD B. SPANGLER.</u> M.D. | | | | 23D. ADDRESS <u>JHH</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>12-20-66</u> | | 24C. NAME of CEMETERY or CREMATORY <u>MT. CARMEL CEM.</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>5712 O'DONNELL ST. BALTO. 24, MD.</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 22 1966</u> | | | |
| 25B. NAME OF REGISTRAR <u>Robert E. Talbot</u> | | 25C. FUNERAL DIRECTOR <u>Charles A. Reiter</u> | | | |
| 25D. ADDRESS <u>901 S. CONKLING ST. BALTO. 21224, MD.</u> | | | | | |

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| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | Registered No. | |
|---|--|--|--|---|--|--|--|
| M.E. CASE NO. | | WILLIAM K. KRAMPF | | 2. DATE AND HOUR PRONOUNCED DEAD | | December 19, 1966 9:45 A. M. | |
| 1. NAME OF DECEASED (Type or Print) | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | B. COUNTY | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | |
| 43 South Baltimore General Hospital (DOA) | | | | Maryland | | Baltimore | |
| D. STREET ADDRESS (If rural, give location) | | 5323 Patrick Henry Drive | | 9. AGE (In years lost birthday) | | 49 | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | |
| Male | | White | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Welder | | | | West Virginia | | U.S.A. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| Henry Krampf | | Unknown | | | | | |
| 17. INFORMANT | | ADDRESS | | Raymond Krampf | | 5223 Patrick Henry Dr. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | Hypertensive and arteriosclerotic cardiovascular disease | | | | | |
| ANTECEDENT CAUSES | | DUE TO | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) DUE TO | | | | | |
| (C) DUE TO | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 2 | | | | Yes | | Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| (Month) (Day) (Year) (Hour) | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE | | CHIEF MEDICAL EXAMINER | | DATE SIGNED | | | |
| Charles S. Springate, M.D. | | Assistant Medical Examiner <input checked="" type="checkbox"/> | | December 19, 1966 | | | |
| EXAMINER'S NAME (Type) | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | | 23C. NAME of CEMETERY or CREMATORY | | 23D. LOCATION (City, town, or county) (State) | |
| Burial | | 12/23/66 | | Cedar Hill Cemetery | | Baltimore, Md. | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | | 24C. FUNERAL DIRECTOR | | ADDRESS | |
| DEC 22 1966 | | Robert E. Taylor | | McCully Funeral Home | | 237 Patapsco Ave. | |

WILLY FORGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|---|--|--|--|
| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12806 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | MARGARET H. POPE | | 2. DATE AND HOUR OF DEATH 12-19-66 12:20 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| Anthuran Hospital of Maryland | | BALTIMORE | | Baltimore, Md. | |
| 5. SEX F | | 6. RACE W | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | |
| 8. DATE OF BIRTH 12-19-30 | | 9. AGE (In years last birthday) 36 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE | |
| 11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME ALBERT B. WEIDNER | |
| 14. MOTHER'S MAIDEN NAME CATHERINE KRONESTEINER | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Raymond Pope | | ADDRESS 2759 Yarnall Rd. Baltimore | | | |
| 18. 199-2-1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Generalized CA. CHF | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. DATE OF OPERATION 0 | | 20. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-18-66 to 12-19-66, that (I) (we) last saw the deceased alive on 12-19-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Lucas C. Vidhyaphum M.D. | | 23B. DATE SIGNED 12-19-66 | | 23C. PHYSICIAN'S NAME (Type) LUCAS CHAIKITCH VIDHYAPHUM M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/23/66 | | 24C. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | |
| 24D. LOCATION Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. DEC 22 1966 | | 25B. NAME OF REGISTRAR Robert E. Talbot | |
| 25C. FUNERAL DIRECTOR McCully Funeral Home | | 25D. ADDRESS 237 Patapsco Ave. | | | |

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

WASHINGTON, D. C. 20530

UNITED STATES DEPARTMENT OF JUSTICE

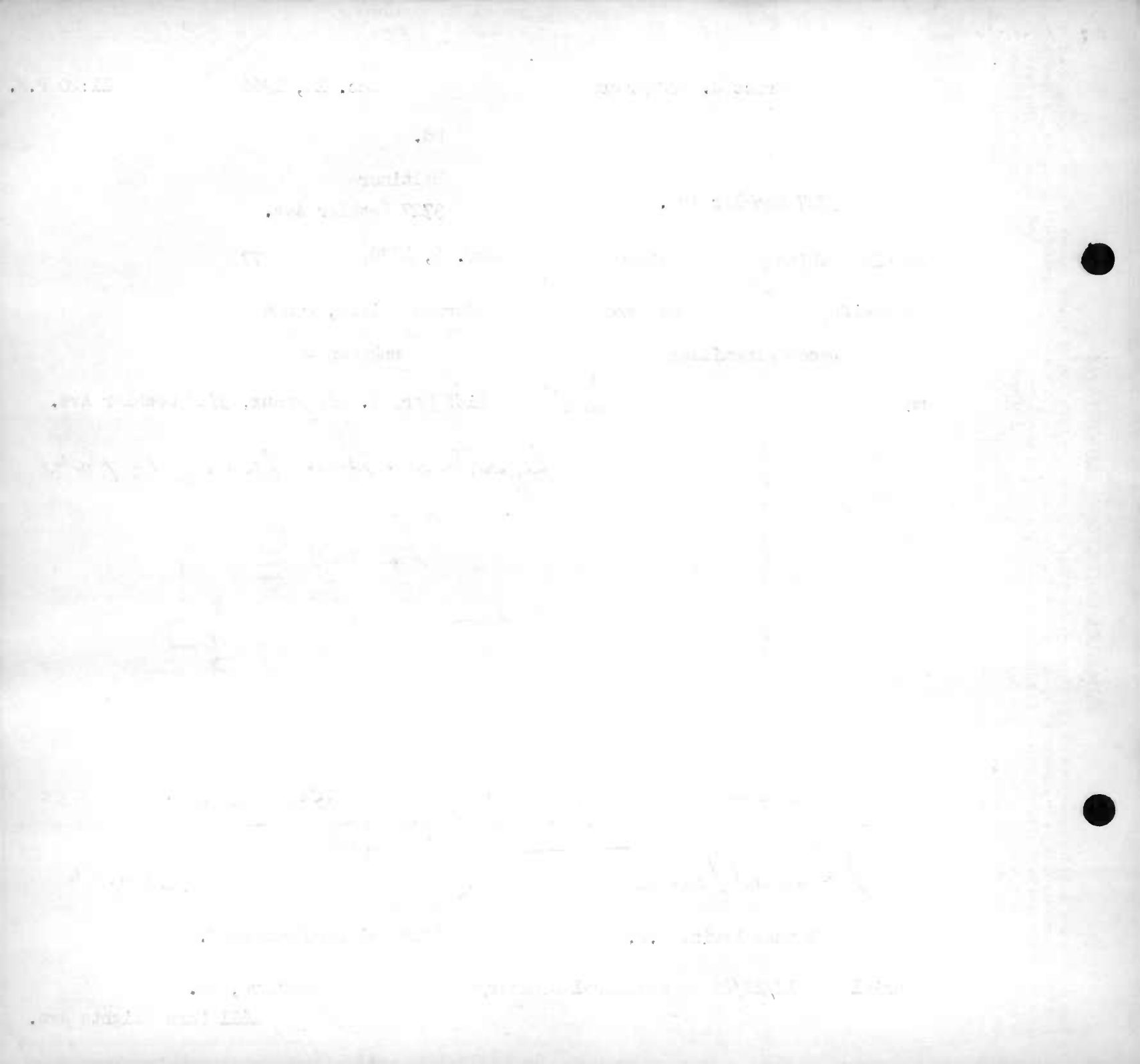
OFFICE OF THE ATTORNEY GENERAL

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

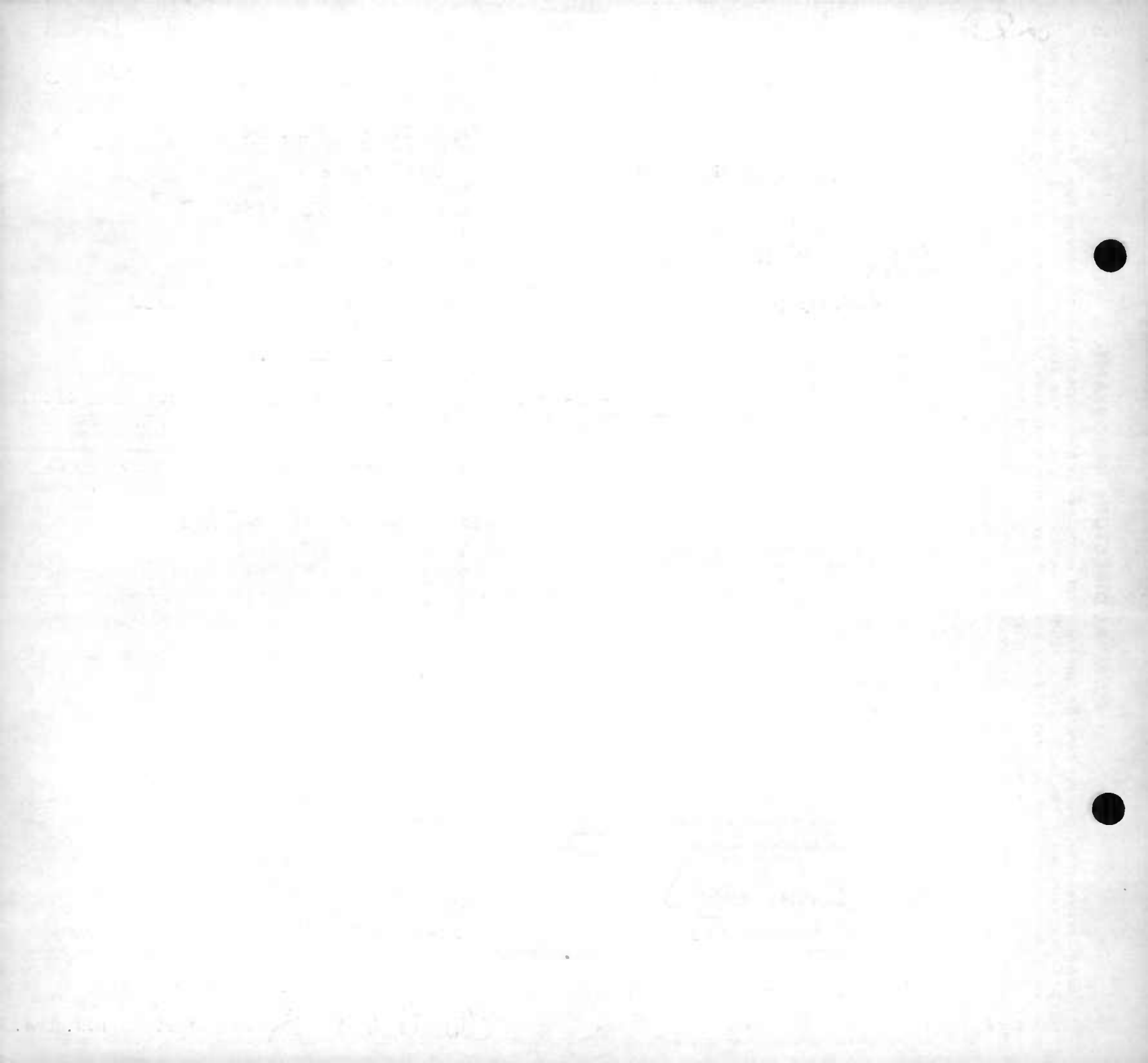
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 12807</u> | |
|--|-------------------------|--|---|--|---|
| BIRTH NO. <u>66 12807</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Grace W. Affayroux | | 2. DATE AND HOUR OF DEATH Dec. 18, 1966 11:20 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>00</u> 3727 Beehler Ave. | | A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3727 Beehler Ave. | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow | 8. DATE OF BIRTH Nov. 6, 1886 | 9. AGE (In years last birthday) 78 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY At Home | | 11. BIRTHPLACE (State or foreign country) Gorsuch Mills, Penna | |
| 13. FATHER'S NAME Jacob Winemiller | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. none | | |
| 17. INFORMANT Miss Mary G. Affayroux, 3727 Beehler Ave. | | | ADDRESS | | |
| 18. 445X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH (A) Hypertensive Heart Disease DUE TO (B) none DUE TO (C) none | | INTERVAL BETWEEN ONSET AND DEATH 10 years | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Aug 17 19 56 to Dec 18 19 66 , that (I) (we) last saw the deceased alive on Dec 18 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Manuel Levin | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 12/19/66 | |
| 23C. PHYSICIAN'S NAME (Type) Manuel Levin, M.D. | | 23D. ADDRESS 4818 Reisterstown Road. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/22/66 | | 24C. NAME OF CEMETERY or CREMATORY Cathedral Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. DEC 22 1966 | | | |
| 25B. NAME OF REGISTRAR Robert E. Johnson | | 25C. FUNERAL DIRECTOR B. Vernon Johnson | | ADDRESS 4611 Park Heights Ave. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. X 66 12808 | |
|---|------------------|---|-----------------------------|--|---|
| 66 12808 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) | | CLIFTON HARRY GASKINS | | 2. DATE AND HOUR OF DEATH 12-17-66 1 30 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 SINAI HOSPITAL OF BALTO. INC. | | A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 6501 LIBERTY ROAD #7 | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 3-11-03 | 9. AGE (In years lost birthday) 63 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) VIRGINIA | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Harry Gaskins | | 14. MOTHER'S MAIDEN NAME Eugenia Mary E. Brown | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 214-01-7639 | | 17. INFORMANT Eugenia Gaskins - 6501 Liberty Road 21207 | |
| 18. 42011 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) MYOCARDIAL INFARCTION DUE TO (B) ASCVD + Hypertensive Heart Disease DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 24 hours. | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION None | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) no. | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-16 1966 to 12-17 1966, that (I) (we) last saw the deceased alive on 12/17 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Leslie Abramowitz | | | | 23B. DATE SIGNED 12-17-66 | |
| 23C. PHYSICIAN'S NAME (Type) LESLIE ABRAMOWITZ | | 23D. ADDRESS SINAI HOSPITAL OF BALTIMORE, INC. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-20-66 | | 24C. NAME OF CEMETERY or CREMATORY Lexington City | |
| 24D. LOCATION (City, town, or county) (State) Lexington North Carolina | | 25A. DATE REC'D BY HEALTH DEPT. DEC 22 1966 | | | |
| 25B. NAME OF REGISTRAR Robert E. Johnson | | 25C. FUNERAL DIRECTOR Elmer H. Hines | | | |
| ADDRESS 4600 Liberty Hgts. Ave. | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 12809 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 66 12809 | |
|--|---------|--|---|---|---|--|---|--|--|
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | | | |
| ETHEL P. TITCOMB | | | | 12-20-66 | | 4:20 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE | | B. COUNTY | | | |
| 33 THE JOHNS HOPKINS HOSPITAL | | | | MARYLAND | | Balt. Co. | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | | |
| | | | | RANDALLSTOWN | | 53-00 | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | | | | |
| | | | | Box 542 A Mc DONOGH RD. | | | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| FEMALE | WHITE | DIVORCED | 1-1-05 | 61 | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | |
| Group Supervisor | | | Aetna Insurance Co. | | Massachusetts | | U.S.A. | | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | | | | | |
| | | | MARY J. POND | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | |
| No | | | 213-20-3244 | | Ann T. Davis McDonogh Rd. Randallstown Md | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) Metastatic Carcinoma of the breast DUE TO | | | | | |
| | | | | (B) DUE TO | | | | | |
| | | | | (C) Carcinoma of the breast - 5 years | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| NONE | | | | | | Yes | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-15-1966 to 12-20-1966, that (I) (we) last saw the deceased alive on 12-20-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| W. B. IAMS | | | | | | | | 12-20-66 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | | 23D. ADDRESS | | | |
| W. B. IAMS | | | | | | J H H | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | |
| Burial | | | Dec 23, 66 | | Woodlawn Cemetery | | Woodlawn, Maryland | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | 25B. NAME OF REGISTRAR | | | 25C. FUNERAL DIRECTOR ADDRESS | | | |
| DEC 23 1966 | | | Robert E. Taylor, Jr. | | | Ellsworth Armacost 4600 Liberty Heights | | | |

TIME . 11:10

RECEIVED

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1
M-320

66 12810

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 12810

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOSEPH B. MATTHEWS

2. DATE AND HOUR PRONOUNCED DEAD

December 18, 1966 6:10 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1906 Park Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

12/25/97

9. AGE (In years
last birthday)

66

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Chauffer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Gaythree Clark Jones 2400 Linden Av

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Pulmonary emphysema

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

December 19, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/23/ 66

23C. NAME of CEMETERY or CREMATORY

National Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore Md

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

DEC 22 1966

Adolphus Halstead

Adolphus Halstead 1206

W North Ave

2025 RELEASE UNDER E.O. 14176

Chandler

Advised

12/25/77

Baltimore Md

Mrs Catherine Clark Jones 3400 Linden St

12/25/77
Baltimore Md
National Center
1206
Adjoining Baltimore

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | BIRTH NO. 66 12811 | | CERTIFICATE OF DEATH | | Registered No. 66 12811 | |
|---|-------------------------|--|---|--|--|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) WALTER H. CHRISTMAS | | | | 2. DATE AND HOUR OF DEATH 12-17-66 | | 8:45 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 THE JOHNS HOPKINS HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY (CARROL COUNTY) C. CITY OR TOWN (If outside city limits, write RURAL and give township) WESTMINSTER D. STREET ADDRESS (If rural, give location) RFD Box #5 336 FOREST HILLS | | | | | |
| 5. SEX MALE WHITE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 10-12-93 | 9. AGE (In years lost birthday) 73 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Photo-engraver | | | 10B. KIND OF BUSINESS OR INDUSTRY Retired | | 11. BIRTHPLACE (State or foreign country) Indiana | | 12. CITIZEN OF WHAT COUNTRY? U. S. | | |
| 13. FATHER'S NAME FRANCIS CHRISTMAS | | | 14. MOTHER'S MAIDEN NAME OLIVE MITCHEM | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes | | | 16. SOCIAL SECURITY NO. 299-07-6094 | | 17. INFORMANT Wife Alvina M. Christmas | | ADDRESS Same as Item 4. | | |
| 18. 420.11-260X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) PULMONARY EDEMA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. DIABETES MELLITUS | | | | (A) DUE TO | | (B) DUE TO | | | |
| 19. 12-12-66 DATE OF OPERATION | | | | 20. BPH CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. YES AUTOPSY? (Yes or No) | | 22. PENDING IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSE OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from DEC 5, 19 66 to DEC 17, 19 66 , that (I) (we) last saw the deceased alive on DEC 17, 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Rainer M. Enloe M.D. | | | | | | 23B. DATE SIGNED 12-17-66 | | | |
| 23C. PHYSICIAN'S NAME (Type) Rainer M. Enloe M.D. | | | | | | 23D. ADDRESS 5041 TRUESDALE AVE | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-20-66 | | 24C. NAME OF CEMETERY or CREMATORY Parklawn Cemetery | | 24D. LOCATION (City, town, or county) (State) Rockville, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 22 1966 | | | 25B. NAME OF REGISTRAR R. A. Pumphrey | | 25C. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Md. | | | | |

.5M, B.

66 12812

BALTIMORE CITY HEALTH DEPARTMENT

66 12812

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN GEORGE BREITENBACH, Sr.

2. DATE AND HOUR PRONOUNCED DEAD

December 21, 1966 6:33 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33 Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2412 McElderry Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

12-16-1918

9. AGE (In years
last birthday)

48

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

KILN OPERATOR

10B. KIND OF BUSINESS OR INDUSTRY

BALTO. BRICK CO.

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JOHN BREITENBACH

14. MOTHER'S MAIDEN NAME

MARGARET KIRBY

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

W.W.II

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Alice M. Breitenbach - 2412 McElderry St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? Yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenacker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/21/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

12-24-66

23C. NAME OF CEMETERY or CREMATORY

OAK LAWN Cem.

23D. LOCATION

(City, town, or county)

(State)

BALTO. MD.

24A. DATE REC'D BY HEALTH DEPT.

DEC 22 1966

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

Hartley Hill - 2334 Jefferson St.

ADDRESS

1. The first part of the paper is devoted to a general
discussion of the problem. It is shown that the
problem is of great importance and that it has
not been completely solved. The author then
presents a new method for solving the problem.

2. In the second part of the paper, the author
applies the new method to a specific case. It is
shown that the method is very effective and that
it can be used to solve a wide range of problems.

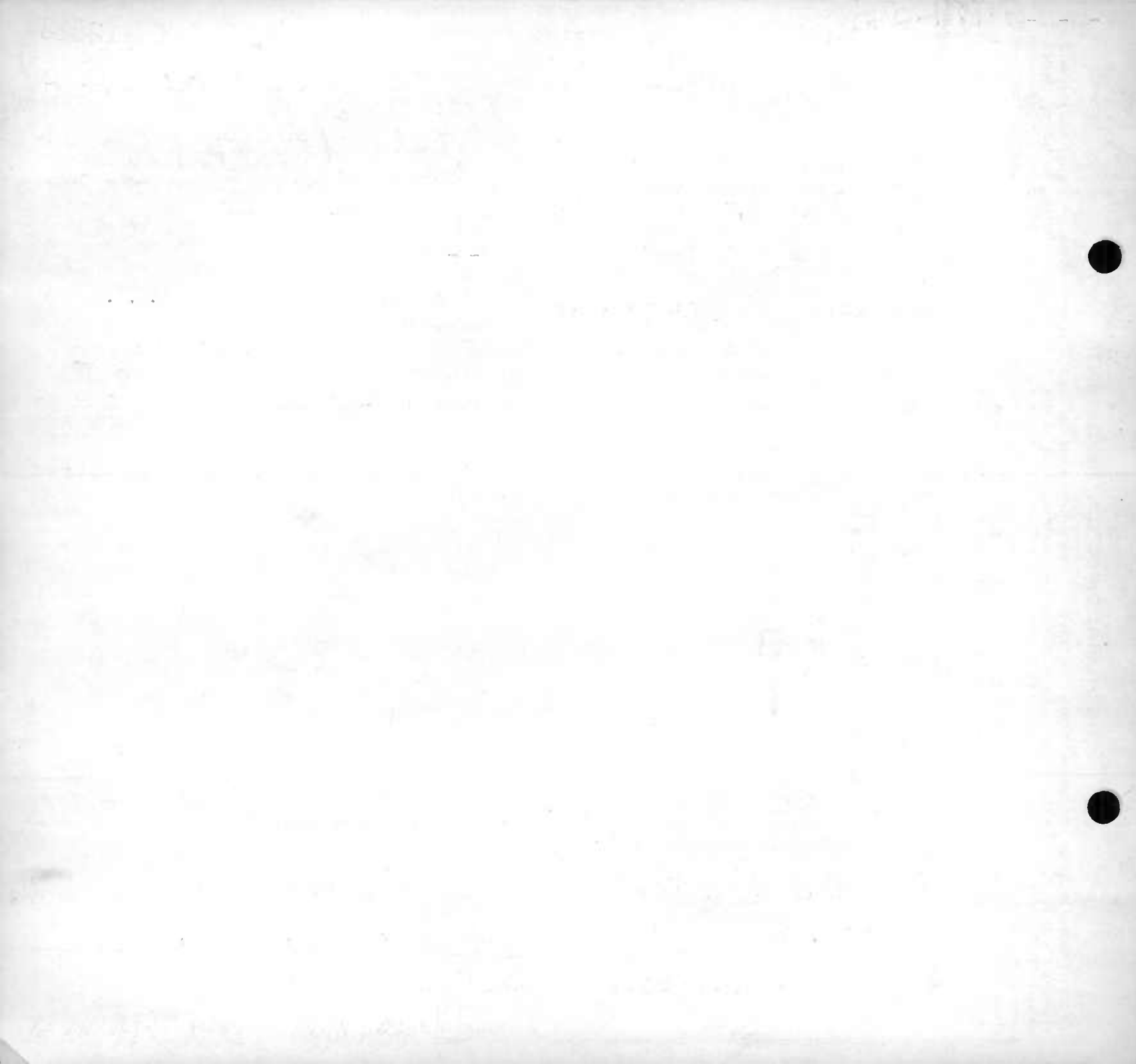
3. The third part of the paper is devoted to a
discussion of the results. It is shown that the
new method is very effective and that it can be
used to solve a wide range of problems.

4. The fourth part of the paper is devoted to a
discussion of the results. It is shown that the
new method is very effective and that it can be
used to solve a wide range of problems.

FUNERAL DIRECTOR: IMPORTANT

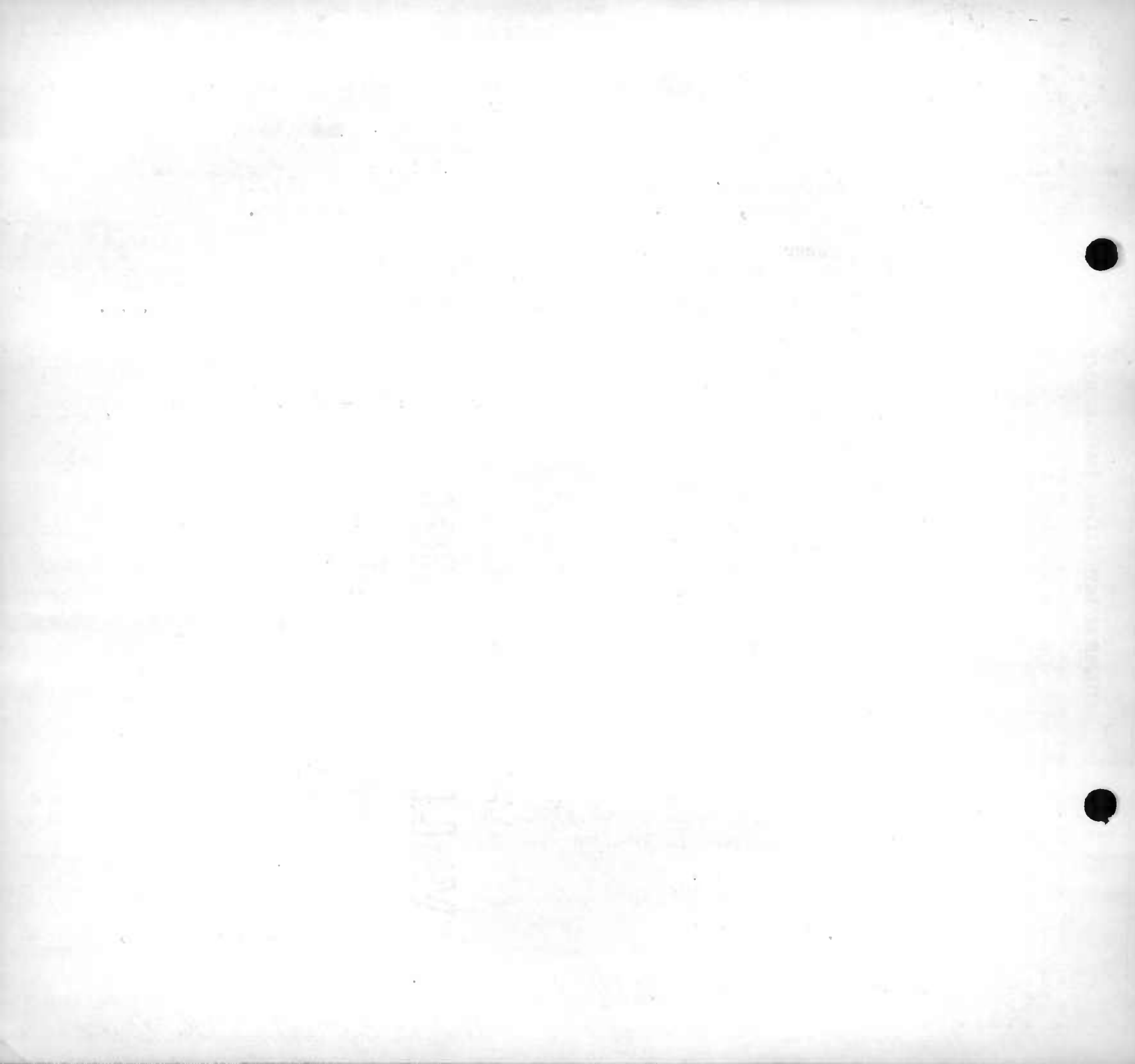
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|--|---------|--|------------------|--|--------------------------------|
| 1-242 66 12813 | | CERTIFICATE OF DEATH | | 66 12813 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| | | RUTH McLAUGHLIN | | 21 DECEMBER, 1966 3 45 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | A. STATE | | B. COUNTY | |
| (If not in hospital or institution, give street address or location) | | Maryland | | Baltimore | |
| Baltimore City Hospitals | | C. CITY OR TOWN | | (If outside city limits, write RURAL and give township) | |
| 4940 Eastern Avenue | | BALTIMORE | | 53-00 | |
| Baltimore, Maryland 21224 | | D. STREET ADDRESS | | (If rural, give location) | |
| | | 3 Eyring Avenue | | 21221 | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. If Under 1 Yr. Months Days |
| Female | White | Married | 8-6-1929 | 37 | 11. If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| WAITRESS | | RESTAURANT | | Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| U.S.A. | | Edward Seabreese | | Ruth Pfeiffer | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | | | Records: BCH-4940 Eastern Avenue 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | | 2 years | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| D | | | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 27 OCTOBER, 1966 to 21 DECEMBER, 1966, that (I) (we) last saw the deceased alive on 21 DECEMBER, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| Daniel D. Foote | | | | 21 DECEMBER, 1966 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Daniel D. Foote | | M.D. 4940 Eastern Avenue, Baltimore, Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| BURIAL | | 12-23-66 | | BALTO. NATIONAL CEM. | |
| | | | | BALTO. MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| DEC 22 1966 | | Robert E. Farkas, M.D. | | Hartley Miller - 2334 Jefferson St. | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| 44-44-53 100 66 12814 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12814 | |
| BIRTH NO. | | M.E. CASE NO. | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Thelma Parker McCoy | | 2. DATE AND HOUR OF DEATH December 21 1966 10⁰⁰ A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | A. STATE Maryland B. COUNTY | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 2325 Edmondson Ave. 21223 | | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED Married | 8. DATE OF BIRTH 4/29/22 | 9. AGE (In years last birthday) 44 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk-Typist | | 10B. KIND OF BUSINESS OR INDUSTRY City Hospital | | 11. BIRTHPLACE (State or foreign country) North Carolina | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME GOVANS | | 14. MOTHER'S MAIDEN NAME Lucille Green | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes. | | 16. SOCIAL SECURITY NO. 215-12-3120 | | 17. INFORMANT ADDRESS records: BCH-4940 Eastern Avenue 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. If means the disease, injury or complication which caused death.) 113X I | | CAUSE OF DEATH (A) Cerebral Edema DUE TO (B) Cerebral Metastases DUE TO (C) Carcinoma of the lung | | INTERVAL BETWEEN ONSET AND DEATH 2 wks 1 yr 5 mo 1 yr 5 mo. | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Septicemia | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from December 1 1966 to December 21 1966 , that (1) (we) last saw the deceased alive on December 21 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) <input type="checkbox"/> (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Joseph Silva | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED December 21, 1966 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Joseph Silva | | 23D. ADDRESS 4940 Eastern Avenue, Baltimore, Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 12-22-66 | 24C. NAME of CEMETERY or CREMATORY Balto. National Cem. | | 24D. LOCATION (City, town, or county) (State) Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 22 1966 | | 25B. NAME OF REGISTRAR Robert E. Edelman | | 25C. FUNERAL DIRECTOR ADDRESS Mortoni Dyett F.H. 1701 Laurens St. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. <u>66 12815</u> | |
| BIRTH NO. <u>66 12815</u> | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) MEAGHER, EUNICE C. | | DECEMBER 20, 1966 10:05 P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL CATON AND WILKENS AVENUES BALTIMORE, MD. 21229 | | A. STATE MARYLAND 21228 B. COUNTY <i>Balts. Co.</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE <i>53-00</i> D. STREET ADDRESS (If rural, give location) 325 GREENLOW ROAD | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED | 8. DATE OF BIRTH 2-3-94 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | | 10B. KIND OF BUSINESS OR INDUSTRY NONE | 9. AGE (In years last birthday) 72 |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME UNKNOWN (DEC'D James Cawthorne) | | 14. MOTHER'S MAIDEN NAME UNKNOWN (DEC'D) | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT HOSPITAL SLIP/CATON & WILKENS AVES. Mrs. Geo. Ackerman-325 Greenlow Rd. | | ADDRESS | |
| 18. <i>443X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardinal Vascular Accident ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hypertensive Cardiovascular Dis. Bronchopneumonia | | CAUSE OF DEATH (A) Cardinal Vascular Accident (B) Hypertensive Cardiovascular Dis. (C) Bronchopneumonia | |
| 19. DATE OF OPERATION | | 20. AUTOPSY? (Yes or No) | |
| 21. TIME OF INJURY (APPROX.) | | 22. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 23. PHYSICIAN'S NAME (Type) JOHN B. HERTS, M.D. | | 24. ADDRESS ST. AGNES HOSPITAL-CATON & WILKENS AVE | |
| 25. DATE REC'D BY HEALTH DEPT. DEC 22 1966 | | 26. NAME OF REGISTRAR Witzke F.D., 4101 Edmondson Ave. | |
| 27. DATE OF DEATH 12-23-66 | | 28. NAME OF CEMETERY OR CREMATORY New Cathedral Cem. | |
| 29. LOCATION (City, town, or county) (State) Baltimore, Md. | | 30. ADDRESS 4101 Edmondson Ave. | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12816 | |
|---|---------------------|---|-----------------------------------|--|---|
| BIRTH NO. 66 12816 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Haines, William W.</u> | | 2. DATE AND HOUR OF DEATH <u>Dec 21/1966</u> <u>1 20</u> P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF INSTITUTION <u>33</u> <u>The Johns Hopkins Hospital</u> | | A. STATE <u>West Virginia</u> B. COUNTY <u>Fairmont</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>V-45</u> D. STREET ADDRESS (If rural, give location) <u>106 Hilltop Drive</u> | | | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u> | 8. DATE OF BIRTH <u>8/9/15</u> | 9. AGE (in years last birthday) <u>51</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 13. FATHER'S NAME <u>Harry L. Haines</u> | | 14. MOTHER'S MAIDEN NAME <u>Verna V. Smith</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT, ADDRESS <u>Hospital Record</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>1. Aortic Stenosis</u> <u>2. Rheumatic Heart Dis</u> | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH <u>4-6 yrs.</u> <u>45 yrs</u> | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12-15-</u> <u>1966</u> to <u>12-21</u> <u>1966</u> , that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>William A. Emerson</u> | | | | 23B. DATE SIGNED <u>12/21/66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>William A. Emerson</u> | | 23D. ADDRESS M.D. <u>The Johns Hopkins Hospital</u> | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12/24/66</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Grandview Mem Park</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Fairmont W. Va.</u> | | 25A. DATE REC'D BY HEALTH DEPT. | | | |
| 25B. NAME OF REGISTRAR <u>Witzke</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>4101 Edmondson Ave</u> | | | |

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Wm. A. Brown



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Badly burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|---|---------------------|---|--|--|---|
| BIRTH NO. 66 12817 | | 66 12817 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Kenneth M. Mc Comas | | | 2. DATE AND HOUR OF DEATH December 19th. 1966 10:10 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Saint Agnes Hospital Caton & Wilkens Aves. 21229 | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Balt. Co C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1107 Gregory Ave. 21207 | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 6/29/19 | 9. AGE (In years last birthday) 47 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gen. Supt. | | 10B. KIND OF BUSINESS OR INDUSTRY Arundel Corp. | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME Late - Cardiff Mc Comas | | | 14. MOTHER'S MAIDEN NAME Ella Miller | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 212-14-8369 | | 17. INFORMANT Mrs. Amelia McComas 1107 Gregory Ave. - #7 | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Anteroseptum ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) Massive Coronary Thrombosis (B) Anteroseptum (C) | | INTERVAL BETWEEN ONSET AND DEATH 3 hrs |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Miss obesity | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 11/16 19 66 to 12/19 19 66 , that (I) (we) last saw the deceased alive on 9/14/66 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) did (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Cliff Ratliff Jr. | | | 23B. DATE SIGNED 12/20/66 | | |
| 23C. PHYSICIAN'S NAME (Type) Cliff Ratliff Jr. | | | 23D. ADDRESS 4605 Edmondson Ave Baltimore, Md. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-22-66 | | 24C. NAME of CEMETERY or CREMATORY Baltimore National Cem. | |
| 24D. LOCATION (City, town, or county) Baltimore, Md. | | 24E. DATE REC'D BY HEALTH DEPT. DEC 22 1966 | | 24F. NAME OF REGISTRAR Robert E. Feltman | |
| 24G. DATE REC'D BY HEALTH DEPT. DEC 22 1966 | | 24H. NAME OF REGISTRAR Robert E. Feltman | | 24I. FUNERAL DIRECTOR Witzke F.D. - 4101 Edmondson Ave. | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. 66 12818 | |
|--|--|--|--|--|--|---|--|---------------------------------------|--|--|--|
| BIRTH NO. 66 12818 | | M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) ROMNEY, CHARLES W. | | | | 2. DATE AND HOUR OF DEATH 12-22-66 3:15 AM M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL WICKENS & CATON AVES BALTO. 29, MD. | | | | | | A. STATE MD. B. COUNTY BALTO. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 101 NORTH ROLLING RD. | | | | | |
| 5. SEX MALE | | 6. RACE CAUCASOON | | 7. MARRIED, NEVER MARRIED MARRIED | | 8. DATE OF BIRTH 09-09-85 | | 9. AGE (In years lost birthday) 81 | | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | | | 10B. KIND OF BUSINESS OR INDUSTRY RAILWAY EXPRESS | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME CHARLES W. ROMNEY SR. (DEC'D) | | | | | | 14. MOTHER'S MAIDEN NAME MARGARET LUTHER (DEC'D) | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS ST. AGNES RECORDS, WILKENS & CATON AVES | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | CAUSE OF DEATH (A) GENERALIZE ARTERIO SCLEROSIS WITH ASCVD DUE TO AND CONGESTIVE HEART FAILURE (B) PYELONEPHRITIS DUE TO (C) DIABETES MELLITUS | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from DECEMBER 16 19 66 to DECEMBER 22 19 66 that (I) (we) last saw the deceased alive on DECEMBER 22, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE JUAN J. CABRERA M.D. | | | | | | 23B. DATE SIGNED | | | | | |
| 23C. PHYSICIAN'S NAME (Type) Juan J. Cabrera | | | | | | 23D. ADDRESS | | | | | |
| 24A. BURIAL CREMATION REMOVE (Specify) Burial | | 24B. DATE 12-24-66 | | 24C. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem. | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 22 1966 | | | | 25B. NAME OF REGISTRAR Robert E. Johnson | | 25C. FUNERAL DIRECTOR Witzke F.D. | | | | ADDRESS 4101 Edmondson Ave. | |

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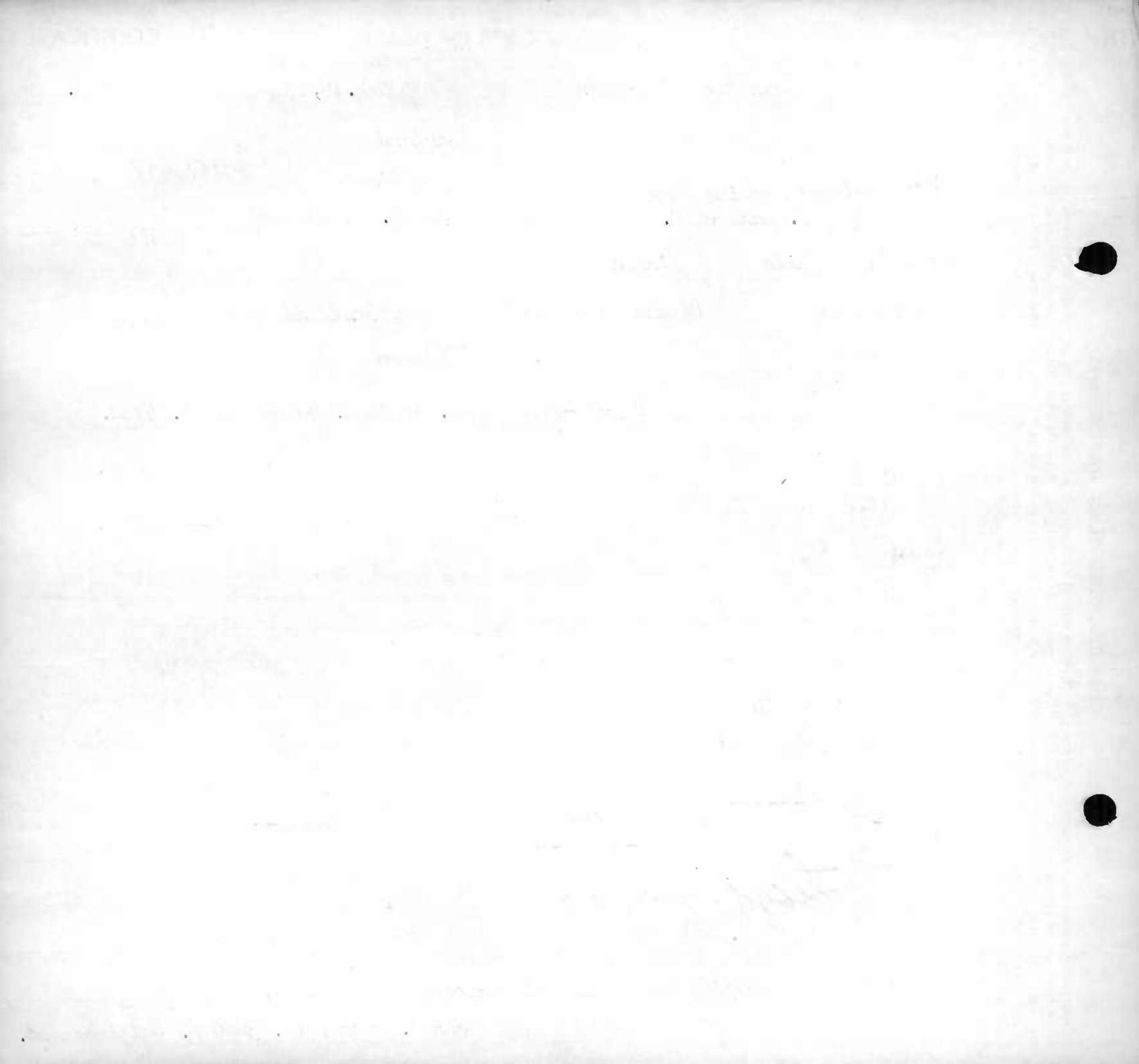
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|--|-------------------------|---|---|--|---|
| BIRTH NO. 66 12819 | | CERTIFICATE OF DEATH | | 66 12819 | |
| M.E. CASE NO. | | | 1. NAME OF DECEASED (Type or Print) <u>Jeanette Dickerson</u> | | |
| 2. DATE AND HOUR OF DEATH <u>Dec. 19, 1966</u> <u>8 A.</u> M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>90 Melchor Nursing Home</u> <u>2327 N. Charles St.</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>9-01</u> D. STREET ADDRESS (If rural, give location) <u>517 E. 41st Street</u> | | |
| 5. SEX <u>Female</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Single</u> | 8. DATE OF BIRTH <u>11/2/1892</u> | 9. AGE (In years lost birthday) <u>74</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Blessed Sacrament</u> | | 11. BIRTHPLACE (State or foreign country) <u>Glasgow, Scotland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>Unknown</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | |
| 16. SOCIAL SECURITY NO. <u>215-24-6417</u> | | 17. INFORMANT <u>Mrs. Annie A. Downes</u> ADDRESS <u>517 E. 41st St.</u> | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>I</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (A) <u>Cerebral hemorrhage with</u> DUE TO <u>hemiplegia (right)</u> (B) <u>Hypertension arteriosclerotic</u> DUE TO <u>ic cardiovascular disease</u> (C) _____ INTERVAL BETWEEN ONSET AND DEATH <u>5 wks.</u> <u>10 yrs.</u> | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>November 13, 1966</u> to <u>December 19, 1966</u> , that (I) (we) lost saw the deceased alive on <u>December 18, 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Lloyd E. Saylor</u> M.D. Attending Phys. <input checked="" type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED <u>12/20/1966</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Lloyd E. Saylor</u> | | 23D. ADDRESS <u>3902 Greenmount Avenue</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12/22/66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral Cemetery</u> | |
| 24D. LOCATION <u>Baltimore, Maryland</u> | | 24E. (Total) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 22 1966</u> | | 25B. NAME OF REGISTRAR <u>John A. Moran, Inc.</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>3000 E. Baltimore St.</u> | |



BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 66 12820 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12820

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM J. BARRETT

2. DATE AND HOUR PRONOUNCED DEAD

December 18, 1966 12:13 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

48^A MARYLAND GENERAL HOSPITAL4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)
1615 Bolton Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)
Never married

8. DATE OF BIRTH

9-13-44

9. AGE (In years
last birthday)20^x 22If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Hardware Fair

11. BIRTHPLACE (State or foreign country)

Balto., Md.

12. CITIZEN OF
WHAT COUNTRY?
USA

13. FATHER'S NAME

William J. Barrett

14. MOTHER'S MAIDEN NAME

Kathryn Hickman

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT
Mrs. Dolores Twigg
3119 Oakford Ave.

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)(A) Gunshot Wound of Head.
DUE TOANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)
Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

1615 Bolton Street

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
12 17 '66 P

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot self in head.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
12/18/6623A. BURIAL CREMATION,
REMOVAL (Specify)

Cremation

23B. DATE

12-21-66

23C. NAME of CEMETERY or CREMATORY

Loudon Park Crematory

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

DEC 22 1966

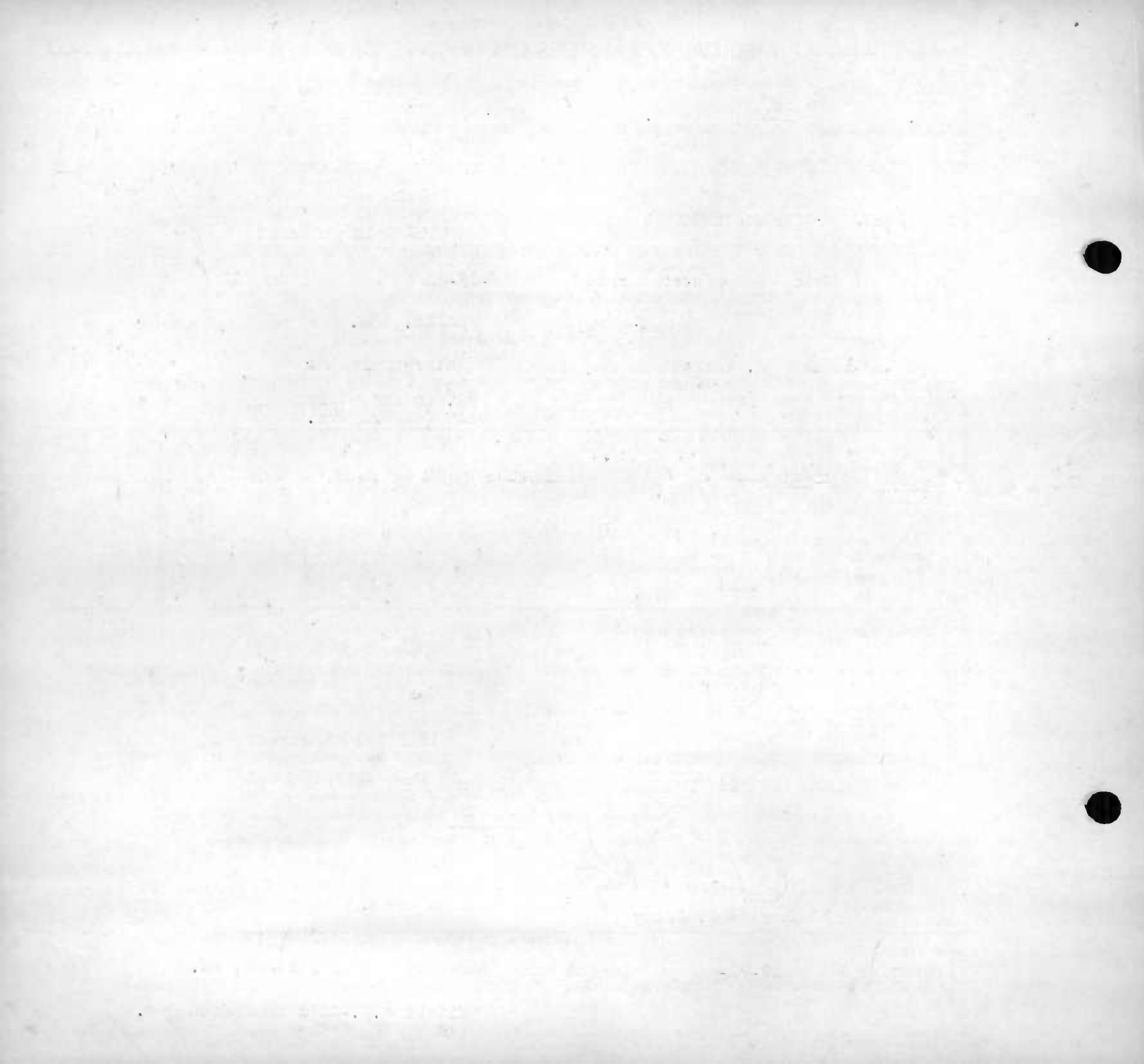
24B. NAME OF REGISTRAR

J. E. F. F.

24C. FUNERAL DIRECTOR

Witzke F.D. - 4101 Edmondson Ave.

ADDRESS



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|--|-----------------------------|--|--|
| BIRTH NO. 66 12821 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12821 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | 12-20-66 1:25P M. | |
| 1. NAME OF DECEASED (Type or Print) RITTER, ADA G. | | 2. DATE AND HOUR OF DEATH | | 12-20-66 1:25P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE B. COUNTY | | MARYLAND BALTIMORE | |
| FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | ZONE 28 53-00 | |
| | | D. STREET ADDRESS (If rural, give location) 426 MONTEMAR AVENUE | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 12-9-02 | 9. AGE (In years last birthday) 64 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) PENNSYLVANIA | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME EDMUND GARDNER | | 14. MOTHER'S MAIDEN NAME MARY HILLER | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 192300433 | | 17. INFORMANT ADDRESS ST AGNES RECORDS-CATON & WILKENS AVES. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) <i>Coronary dilatation RV, CHF, renal failure</i> DUE TO (B) <i>Mitral Valvulitis Rheumatic & Atherosclerosis @ 10 yrs</i> DUE TO (C) <i>Pituitary Adenoma</i> | | INTERVAL BETWEEN ONSET AND DEATH 29 | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from NOVEMBER 25 19 66 to DECEMBER 20 1966, that (I) (we) last saw the deceased alive on DECEMBER 20 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Philip Whelan</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-20-66 | |
| 23C. PHYSICIAN'S NAME (Type) Philip Whelan | | 23D. ADDRESS M.D. ST Agnes Hosp. / Caton & Wilkens Aves. #29 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-23-66 | | 24C. NAME of CEMETERY or CREMATORY Paxtang Cemetery | |
| 24D. LOCATION Dauphin County Pennsylvania | | 25A. DATE REC'D BY HEALTH DEPT. DEC 22 1966 | | 25B. NAME OF REGISTRAR Wm. Cooks Brooks | |
| 25C. FUNERAL DIRECTOR Wm. Cooks Brooks | | 25D. TOWSON INC. | | 25E. TOWSON, MD. | |

1
T-653

66 12822

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12822

| | | | | | |
|---|---|---|--|---|---|
| BIRTH NO. M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Thomas Trent Sr. | | 2. DATE AND HOUR PRONOUNCED DEAD 12/20/66 12:20 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 605 | |
| FULL NAME OF HOSPITAL OR INSTITUTION 35 Church Home and Hospital | | D. STREET ADDRESS (If rural, give location) 15 N. Broadway | | | |
| 5. SEX male | 6. RACE white | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 8-28-08 | 9. AGE (In years last birthday) 58 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver | | 10B. KIND OF BUSINESS OR INDUSTRY Motor Freight | | 11. BIRTHPLACE (State or foreign country) Virginia | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Van Trent | | 14. MOTHER'S MAIDEN NAME Melinda Grady | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | |
| 16. SOCIAL SECURITY NO. 217-16-4309 | | 17. INFORMANT Thomas Trent Jr. | | ADDRESS Baltimore, Md. 23E. 21th. St. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) no | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE Werner U. Spitz, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 12/20/66 | |
| | | M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | 23B. DATE 12-22-66 | 23C. NAME of CEMETERY or CREMATORY Old Glade Presbyterian | 23D. LOCATION (City, town, or county) (State) Glade Springs, Virginia | | |
| 24A. DATE REC'D BY HEALTH DEPT. DEC 22 1966 | 24B. NAME OF REGISTRAR Robert E. Johnson | 24C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks 1217 St. Paul St. Baltimore, Maryland | | | |

WALTON ROAD

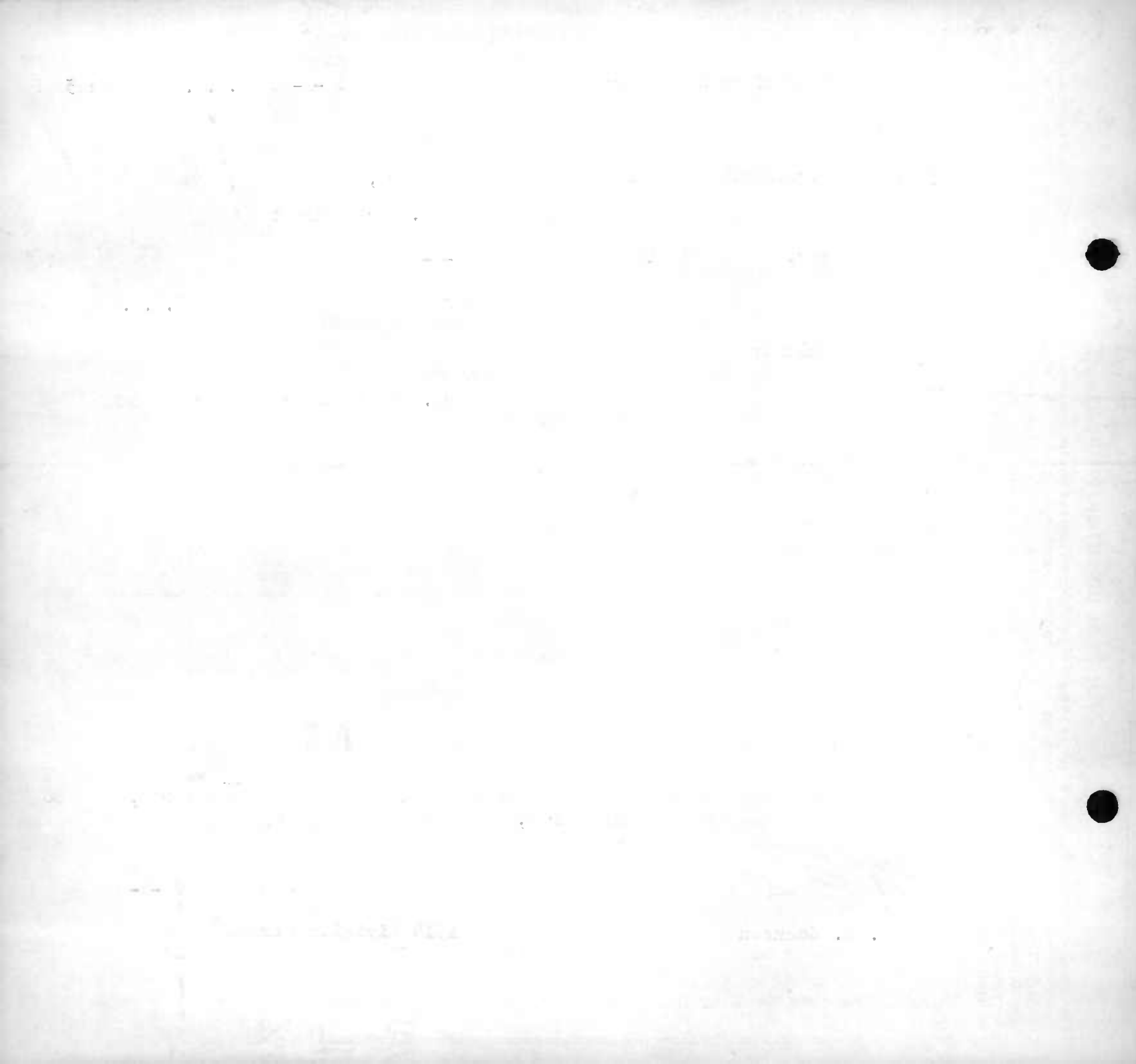
WALTON ROAD

Released By M.E. office on Nov. 1966

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12823 | |
|---|---------------|--|--------------------------|--|-----------------------------|
| BIRTH NO. 66 12823 | | | | M.E. CASE NO. 66 28209 | |
| 1. NAME OF DECEASED (Type or Print) Baby of Evelyn Rogers | | | | 2. DATE AND HOUR OF DEATH 12-3-66 D.O.A. 4:25 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital | | A. STATE Maryland | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 805 N. Carey Street | | | |
| 5. SEX MALE | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH 12-3-66 | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [] Yes, give war or dates of service | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Evelyn Roger (Mother) | |
| | | | | ADDRESS SAME | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| I This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death. | | (A) Premature New Born | | | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) [] Yes [X] No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) [] | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At [] Not While At Work [] | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from December 3, 19 66 to December 3, 19 66, that (I) (we) last saw the deceased alive on December 3, 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE W. L. Johnson | | | | 23B. DATE SIGNED 12-5-66 | |
| 23C. PHYSICIAN'S NAME (Type) W. L. Johnson | | | | 23D. ADDRESS 1514 Division Street | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 12-12-66 | | 24C. NAME OF CEMETERY or CREMATORY | |
| 24D. LOCATION (City, town, or county) (State) | | 25A. DATE REC'D BY HEALTH DEPT. DEC 22 1966 | | | |
| 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 12824 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12824 | |
|---|--|---|--|---|--|---|--|
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) BAER, IRENE VIRGINIA | | | | 2. DATE AND HOUR OF DEATH 20 DEC. 66 12³⁰ A M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL | | If not in hospital or institution, give street address or location | | A. STATE MARYLAND | | B. COUNTY BALTIMORE | |
| 5. SEX F | | 6. RACE W | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED | | 8. DATE OF BIRTH 06-01-98 68 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED TEACHER | | 10B. KIND OF BUSINESS OR INDUSTRY BALTO CITY PUBLIC SCHOOLS | | 11. BIRTHPLACE (State or foreign country) M.D. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME JOHN BAER | | | | 14. MOTHER'S MAIDEN NAME AURORA STUECKER | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. und | | 17. INFORMANT MRS. EDWIN K. GONTRUM ADDRESS 7509 CLUB RD RUXTON, 21204 Md. | | | |
| 18. 420.1 I | | | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) myocardial infarction, old | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) pulmonary edema, both lung | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | (C) U.K. Born | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 15 DEC 1966 to 20 DEC 1966 that (I) (we) last saw the deceased alive on 20 DEC 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Sidney E. Kirkley | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 20 DEC 66 | |
| 23C. PHYSICIAN'S NAME (Type) SIDNEY E. KIRKLEY, | | | | 23D. ADDRESS THE UNION MEMORIAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/22/1966 | | 24C. NAME of CEMETERY or CREMATORY Druid Ridge | | 24D. LOCATION (City, town, or county) (State) Pikesville, Balto. Co., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 22 1966 | | 25B. NAME OF REGISTRAR W. E. Jenkins | | 25C. FUNERAL DIRECTOR ADDRESS H. W. Jenkins & Sons Co. 4905 York Rd. Baltimore 12, Md. | | | |

Page 2 of 2

10/10/10

MEMORANDUM

TO: Mr. [Name]

FROM: Mr. [Name]

SUBJECT: [Subject]

1. [Text]

2. [Text]

3. [Text]

4. [Text]

5. [Text]

6. [Text]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|--|-----------------------------|---|---|
| BIRTH NO. 66 12825 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12825 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) HARLAN EDWIN (JUDGE) | | 2. DATE AND HOUR OF DEATH 20 December 1966 1 AM M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL BALTIMORE 44 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 27-12 D. STREET ADDRESS (If rural, give location) 219 GOODALE ROAD 21212 | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) MARRIED | 8. DATE OF BIRTH 11-9-09 | 9. AGE (In years lost birthday) 57 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) JUDGE-LAWYER | | 10B. KIND OF BUSINESS OR INDUSTRY JUDGE-BENCH | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? AMERICAN-USA | | 13. FATHER'S NAME ENOCH HARLAN | | 14. MOTHER'S MAIDEN NAME MARY BENSON | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 214-26-8222 | | 17. INFORMANT MAS. KATHARINE H. HARLAN (SAME) | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH (A) Multiple pulmonary emboli w/ infarction (B) Acute myocardial infarction (C) Coronary arteriosclerosis Congestive heart failure Chronic Hypertension | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-11-1966 to 12-20-1966, that (I) (we) last saw the deceased alive on 12-11-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Fridtjofur Bjornsson | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) FRIDTJOFUR BJORNSSON | | 23D. ADDRESS THE UNION MEMORIAL HOSPITAL UNION MEMORIAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/22/1966 | | 24C. NAME OF CEMETERY or CREMATORY Druid Ridge | |
| 24D. LOCATION Pikesville, Balto. Co., Md. | | 24E. LOCATION (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 22 1966 | | 25B. NAME OF REGISTRAR Robert E. Sedona | | 25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md. | |

1944-1945

1944-1945

MARYLAND

UNION MEMORIAL HOSPITAL
BALTIMORE

BALTIMORE
219 GOODALE ROAD 21215

MALE WHITE MARRIED

11-9-CP 27

JUDGE JUDGE

MARYLAND AMERICAN

ENCH HARLAN

MARY BENSON

RECORDED & INDEXED
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FBI - BALTIMORE
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100-100000-100000
100-100000-100000

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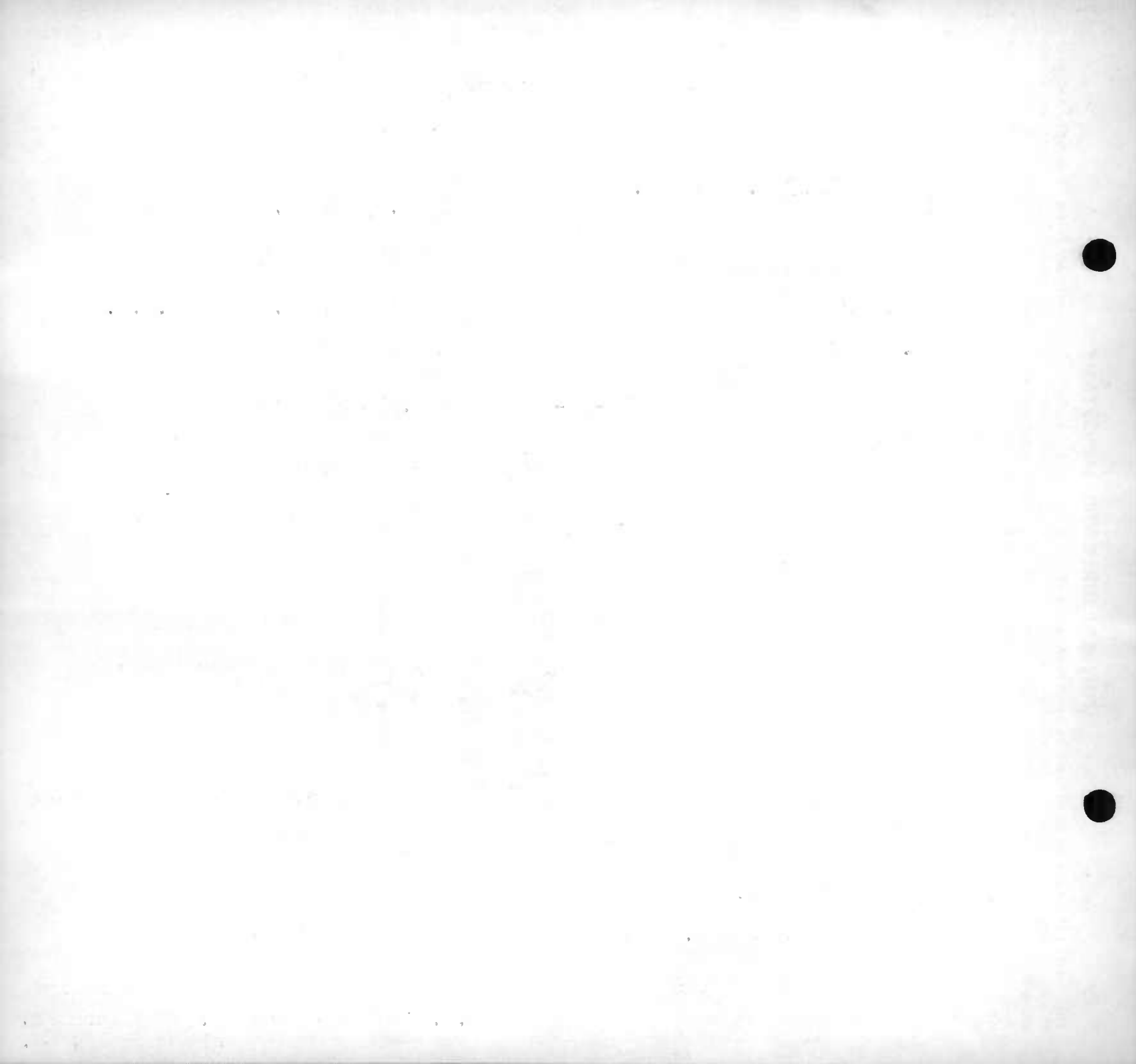
ERICKSON
100-100000-100000

X
UNION MEMORIAL HOSPITAL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

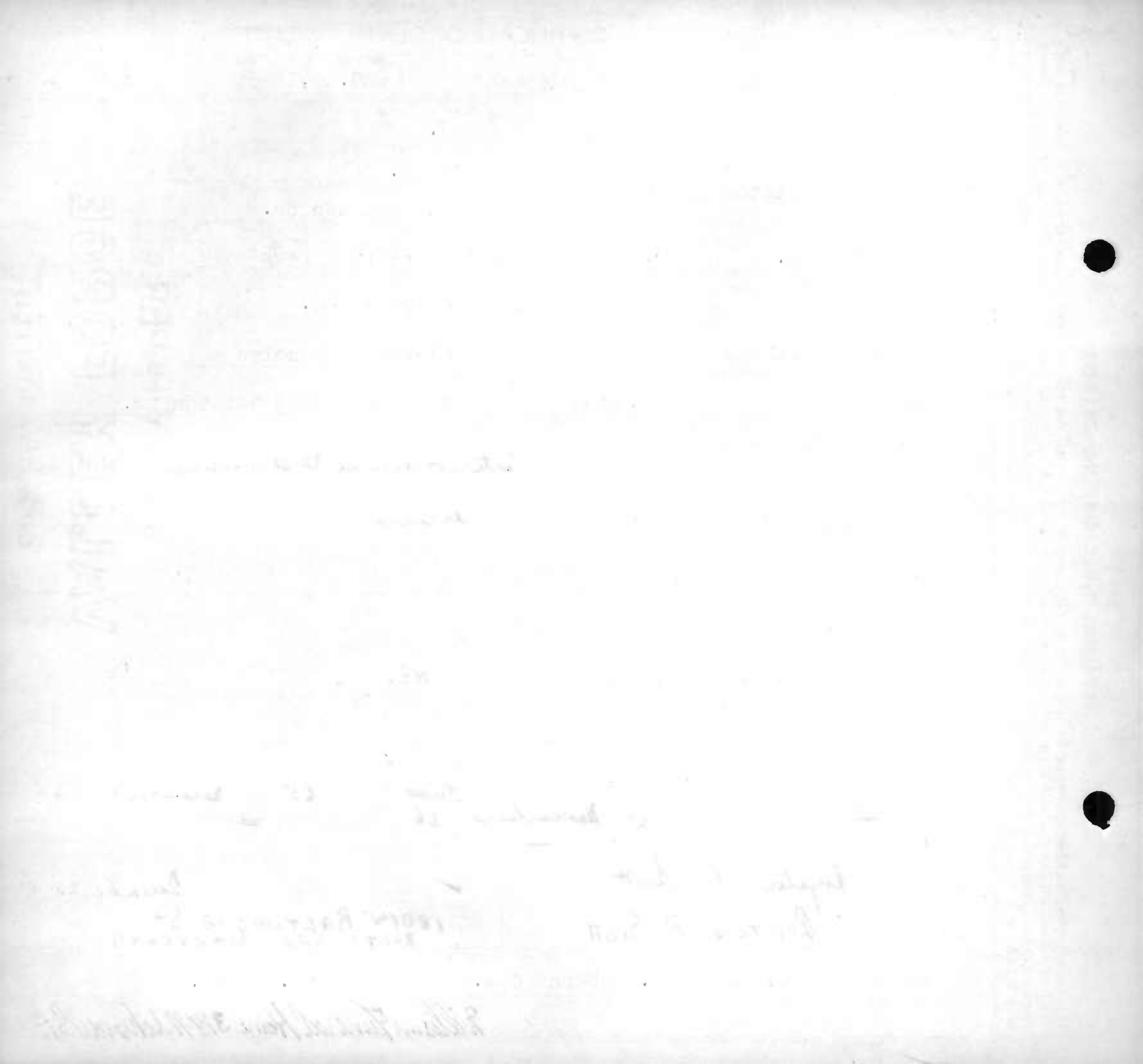
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 12826</u> |
|--|--|--|--|------------------------------------|
| BIRTH NO. <u>66 12826</u> | | CERTIFICATE OF DEATH | | |
| M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | |
| <u>Mary Elizabeth Ebersberger</u> | | <u>12/18/1966</u> <u>6 30 A.M.</u> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital) or institution, give street address or location | | A. STATE <u>Maryland</u> | | |
| <u>00 1913 E. 32nd St.</u> | | B. COUNTY | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | |
| | | <u>Baltimore</u> <u>9-06</u> | | |
| | | D. STREET ADDRESS (If rural, give location) | | |
| | | <u>1913 E. 32nd St.</u> | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) |
| <u>F</u> | <u>W</u> | <u>Widowed</u> | <u>7/14/1884</u> | <u>82</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
| <u>Housewife</u> | | <u>Own Home</u> | <u>Baltimore, Md.</u> | <u>U.S.A.</u> |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | |
| <u>John Voelker</u> | | | <u>Clayanna Lemke</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | |
| <u>No</u> | | <u>218-32-1152</u> | <u>John M. Ebersberger</u> <u>(Same)</u> | |
| 18. <u>420.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) <u>Arteriosclerotic heart disease 3 yrs</u> DUE TO (B) <u>Arteriosclerosis</u> DUE TO (C) _____ | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| <u>0</u> | | <u>No</u> | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| <input type="checkbox"/> | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |
| | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Jan 1951</u> to <u>12/18 1966</u> , that (I) (we) last saw the deceased alive on <u>12/17 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED |
| <u>Conrad L. Richter</u> | | | | <u>12/19/66</u> |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | |
| <u>Conrad L. Richter</u> | | <u>3128 Harford Road</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME of CEMETERY or CREMATORY | 24D. LOCATION (City, town, or county) | (State) |
| <u>Burial</u> | <u>12/21/1966</u> | <u>Baltimore</u> | <u>Baltimore</u> | <u>Maryland</u> |
| 25A. DATE REC'D BY HEALTH DEPT. | 25B. NAME OF REGISTRAR | 25C. FUNERAL DIRECTOR ADDRESS | | |
| <u>DEC 22 1966</u> | <u>Robert E. Jenkins</u> | <u>H.W. Jenkins & Sons Co. 4905 York Rd. Baltimore 12, Md.</u> | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. 66 12827 | | CERTIFICATE OF DEATH | | Registered No. 66 12827 | |
|---|--|--|--|---|--|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) SARAH YOUNG GILLIAM | | | | 2. DATE AND HOUR OF DEATH DEC. 18, 1966 8:30 A. M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 3649 Gelston Drive | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto. D. STREET ADDRESS (If rural, give location) 3649 Gelston Dr. | | | | | |
| 5. SEX Female | | 6. RACE Col. | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widow | | 8. DATE OF BIRTH June 2, 1874 | | 9. AGE (In years last birthday) 92 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Dinwoodie Va. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Thomas Matthews | | | | 14. MOTHER'S MAIDEN NAME Catherine Nicholas | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT ADDRESS Mary Contee 3649 Gelston Dr. | | | |
| 18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) Anterior wall Myocardial Infarction DUE TO (B) disease DUE TO (C) | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from June 19 65 to December 7 19 66 , that (I) (we) last saw the deceased alive on November 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Royston B. Scott | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED December 20 66 | |
| 23C. PHYSICIAN'S NAME (Type) ROYSTON B. SCOTT | | | | 23D. ADDRESS 1801 W BALTIMORE ST BALTIMORE, MARYLAND. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/22/66 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem. | | 24D. LOCATION (City, town, or county) (State) Balto. Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 22 1966 | | 25B. NAME OF REGISTRAR Robert E. Johnson | | 25C. FUNERAL DIRECTOR Williams Funeral Home | | ADDRESS 319 N. Howard St. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|--|--|--|---|
| BIRTH NO. 66 12828 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12828 | |
| CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED (Type or Print) Ethel P. Hammond | | | 2. DATE AND HOUR OF DEATH 12-19-66 11:40 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 25-32 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore General Hosp (If not in hospital or institution, give street address or location) | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #21225 | | |
| D. STREET ADDRESS (If rural, give location) 1302 Shellbank Rd. | | | | | |
| 5. SEX F | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow | 8. DATE OF BIRTH 2-21-1897 | 9. AGE (In years last birthday) 69 | 10. Under 1 Yr. Months: Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Balto., Md. |
| 12. CITIZEN OF WHAT COUNTRY? | | | 13. FATHER'S NAME James Payne | | |
| 14. MOTHER'S MAIDEN NAME Mary Smith | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | |
| 16. SOCIAL SECURITY NO. 218-14-7916 | | | 17. INFORMANT Clarence Syc ADDRESS 133 S. Morley St | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 422.1 I | | | CAUSE OF DEATH (A) DUE TO Cerebral Haemorrhage days | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) DUE TO ASCVDs | | |
| | | | (C) Generalized Arterio-sclerosis | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that the (this hospital) attended the deceased from 12-17 19 66 to 12-19 19 66 , that the (we) last saw the deceased alive on 12-19 19 66 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Rifat Abousy M.D. | | | | 23B. DATE SIGNED 12-19-66 | |
| 23C. PHYSICIAN'S NAME (Type) Rifat Abousy M.D. | | | | 23D. ADDRESS 1213 Light St. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/22/66 | | 24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cem | |
| 24D. LOCATION (City, town, or county) Balto Md. | | 24E. (State) Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 22 1966 | | 25B. NAME OF REGISTRAR Robert E. Johnson | | 25C. FUNERAL DIRECTOR Williams Funeral Home ADDRESS 3197 Schroeder St | |

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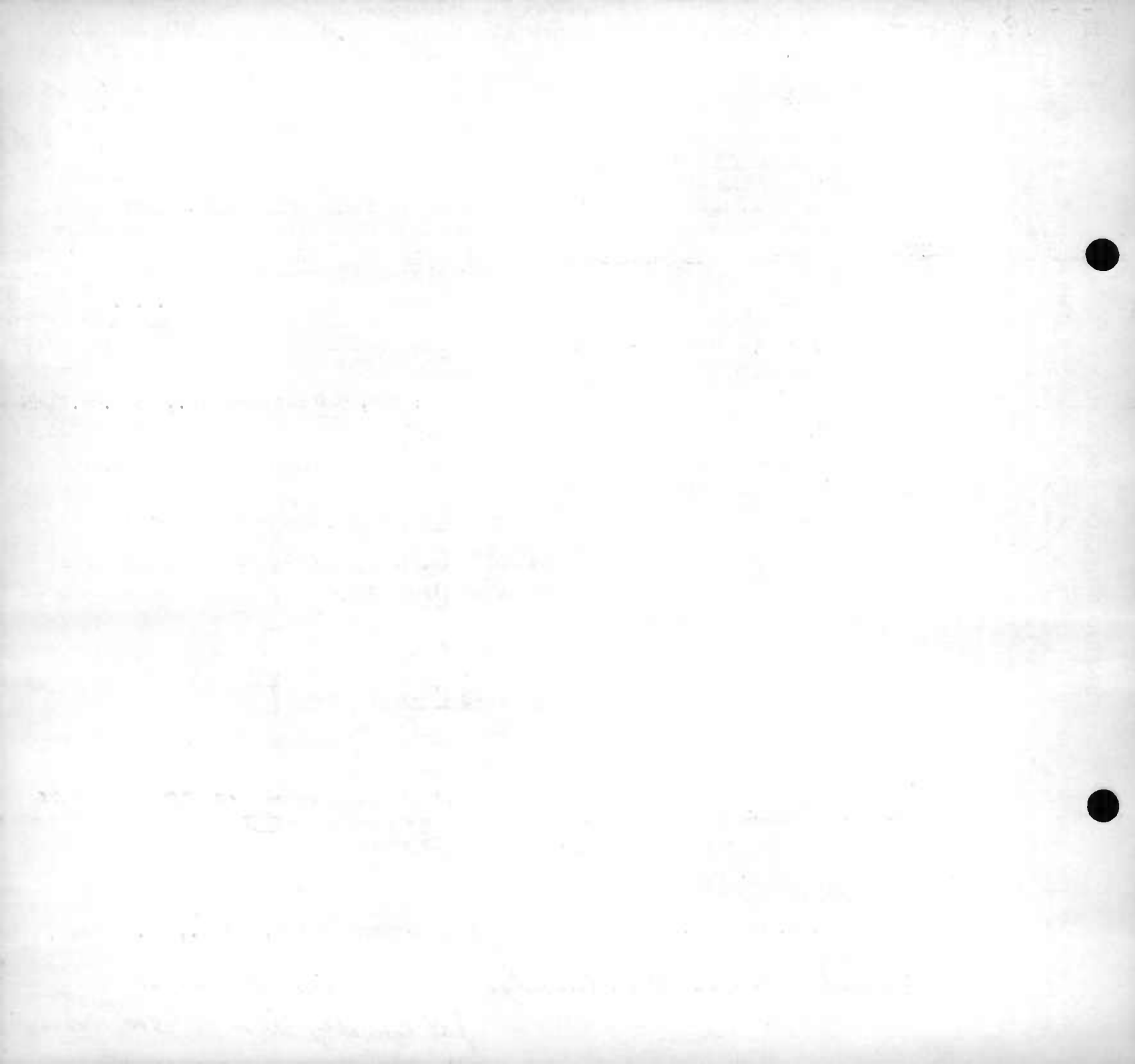
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48-32-87
NW

FUNERAL DIRECTOR: IMPORTANT!

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 48-32-87 NW | | 66 12829 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12829 | |
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) HEILAND, SOPHIE | | | |
| 2. DATE AND HOUR OF DEATH 12-20-66 10:00 A.M. | | | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balt Co. D. STREET ADDRESS (If rural, give location) 3230 OLD NORTH POINT ROAD - 21222 | | | |
| 5. SEX FEMALE | | 6. RACE WHITE | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED | | 8. DATE OF BIRTH 5/30/18 | |
| 9. AGE (In years lost birthday) 48 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME EMIL HEILAND - Deceased | | | | 14. MOTHER'S MAIDEN NAME THERESA JACOB | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT RECORDS: BCH, 4940 Eastern Ave., Balto, Md. 21224 | |
| 18. 710X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Shock poss 20% valvular rupture DUE TO (A) Shock poss 20% valvular rupture INTERVAL BETWEEN ONSET AND DEATH 1-3 hr. | | | | 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) Subacute Bact. Endocarditis 2 mo (C) Rheumatic mitral valvular disease & insufficiency unknown | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II | | | | 21. MEDICAL CERTIFICATION | | | |
| 19A. DATE OF OPERATION Venous cutdown | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Shock | | 20A. AUTOPSY? (Yes or No) yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from 12-18 19 66 to 12-20 19 66 , that (I) (we) lost saw the deceased alive on 12-20 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE S.W. Douglas, III M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | |
| 23C. PHYSICIAN'S NAME (Type) S. W. DOUGLAS, III | | 23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 Eastern Avenue, Balto., Md. 21224 | | 23B. DATE SIGNED 12-20-66 | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | |
| 24B. DATE 12/23/66 | | 24C. NAME OF CEMETERY or CREMATORY Meadowridge | | 24D. LOCATION (City, town, or county) (State) Balto Md | | 25A. DATE REC'D BY HEALTH DEPT. DEC 23 1966 | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR J. H. Connelly, Son | | 25D. ADDRESS 300 Moore | | VS 150-REV. 1/1/65 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. 66 12830 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12830 | |
| M.E. CASE NO. | | | 1. NAME OF DECEASED (Type or Print) Edward M. Kane | | |
| 2. DATE AND HOUR OF DEATH December 18, 1966 9:50 A.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | A. STATE Maryland | | |
| 43 South Baltimore General Hosp. | | | B. COUNTY Baltimore | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | D. STREET ADDRESS (If rural, give location) | | |
| 25-04 | | | 3713 S. Hanover St. | | |
| 5. SEX M. | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH Jan 12, 1892 | 9. AGE (In years last birthday) 74 | 10. If Under 1 Yr. Months Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Handyman | | | 10B. KIND OF BUSINESS OR INDUSTRY Amusement | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. |
| 12. CITIZEN OF WHAT COUNTRY? U. S. | | | 13. FATHER'S NAME Samuel Kane | | |
| 14. MOTHER'S MAIDEN NAME Ella Robinson | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | |
| 16. SOCIAL SECURITY NO. 212-16-8025 | | | 17. INFORMANT Mr. Melvin L. Kane Box 44B Rt. 2 Severn, Md. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | CAUSE OF DEATH | | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | Ca of the lung | | |
| ANTECEDENT CAUSES | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from 12-13 19 66 to 12-18 19 66, that (we) last saw the deceased alive on 12-18 19 66 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Camilo C. Balacuit M.D. | | | 23B. DATE SIGNED Dec. 19, 1966 | | |
| 23C. PHYSICIAN'S NAME (Type) Camilo C. Balacuit M.D. | | | 23D. ADDRESS 1213 Light St. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Dec. 21, 1966 | | 24C. NAME OF CEMETERY or CREMATORY Glen Haven Mem. Pk. | |
| 24D. LOCATION (City, town, or county) Glen Burnie, A. A. Co., Md. | | 24E. STATE (State) Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 23 1966 | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR George J. Gonce 4001 Ritchie Hwy. (21225) | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---|-------------------------|--|---|--|---|---|------------------------------|
| BIRTH NO. 66 12831 | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 66 12831 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Emma Hatley Carter Brown | | | | 2. DATE AND HOUR OF DEATH December 19, 1966 9¹⁵ P M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Long Green Home | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1102 147 W. Lanvale St. | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH April 16, 1879 | 9. AGE (In years last birthday) 86 | If Under 1 Yr. Months: Days: Hours: Min. | If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Fairfax Co., Virginia | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME Landon Edward Carter | | | 14. MOTHER'S MAIDEN NAME Margaret Rose Carter | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 213-48-1402 | | 17. INFORMANT Mr. G. Harrie Brown | | ADDRESS Same |
| 18. 331 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) Cerebral Hemorrhage Arterio-sclerotic Disease Arterio-sclerosis Cerebri Hypertension | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | | INTERVAL BETWEEN ONSET AND DEATH 1 hr 11 | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Oct 1960 to Dec 19 1966 , that (I) (we) last saw the deceased alive on Dec 19 - 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE W F Woody M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/> | | | | | | 23B. DATE SIGNED 12-21-66 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. William F. Woody M.D. | | | | 23D. ADDRESS 1403 Park Ave. Baltimore, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-22-66 | | 24C. NAME OF CEMETERY or CREMATORY St. Pauls Episcopal | | 24D. LOCATION (City, town, or county) (State) Haymarket, Virginia | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 23 1966 | | 25B. NAME OF REGISTRAR W E. Woody | | 25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc. | | ADDRESS 6500 York Rd. Baltimore, Md. 21212 | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12832 | |
|---|-------------------|--|--------------------------------------|--|---|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 66, 12832 | | M.E. CASE NO. 212 | | 1. NAME OF DECEASED (Type or Print) <i>Frisby, William</i> | |
| 2. DATE AND HOUR OF DEATH <i>20 Dec 66 8:45 P.M.</i> | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Dukeland Nursing Home</i> | | (If not in hospital or institution, give street address or location) | | | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) | | A. STATE <i>Md</i> B. COUNTY <i>Harford Co.</i> | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | <i>Aberdeen, 62-28</i> | | | |
| D. STREET ADDRESS (If rural, give location) | | <i>1501 Dukeland St. 419 Baltimore St.</i> | | | |
| 5. SEX <i>M</i> | 6. RACE <i>N.</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Divorced</i> | 8. DATE OF BIRTH <i>15 Nov. 1890</i> | 9. AGE (In years last birthday) <i>76</i> | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Railroad</i> | | 11. BIRTHPLACE (State or foreign country) <i>Har. Co. Maryland.</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 13. FATHER'S NAME <i>George Frisby</i> | | 14. MOTHER'S MAIDEN NAME <i>Harriett Green</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>717-07-5554</i> | | 17. INFORMANT <i>Hazel Frisby, Aberdeen, Md.</i> | |
| 18. <i>443X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH (A) DUE TO <i>BRONCHO PNEUMONIA</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>18 days</i> | |
| ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO <i>ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE & HYPERTENSION</i> | | <i>20 YRS</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>THROMBOARTERITIS OBLITERANS</i> | | | | <i>5 YRS</i> | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>30 Aug 66</i> to <i>20 Dec 66</i> , that (I) (we) last saw the deceased alive on <i>20 Dec 66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>W. C. Walden</i> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>20 Dec 66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>W. C. WALDEN</i> | | 23D. ADDRESS <i>1501 DUKELAND ST</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12/23/66</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Mt Calvary Cemetery</i> | |
| 24D. LOCATION (City, town, or county) <i>Aberdeen, Harford</i> | | (State) <i>Md.</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 23 1966</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Tarring</i> | | 25C. FUNERAL DIRECTOR <i>John H. Tarring</i> | |
| | | | | ADDRESS <i>Tarring Funeral Home, Aberdeen, Md.</i> | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 12833</u> |
|---|-------------------------|--|--|--|
| BIRTH NO. <u>66 12833</u> | | CERTIFICATE OF DEATH | | |
| M.E. CASE NO. <u>66 12833</u> | | 1. NAME OF DECEASED (Boula G. Blair) <u>BEULAH BLAIR</u> | | |
| 2. DATE AND HOUR OF DEATH <u>Dec. 19, 1966</u> <u>8:50 A.M.</u> | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>90 Gould Convalesarium</u> <u>6116 Bel Air Rd.</u> <u>Baltimore, Maryland</u> | | A. STATE <u>Maryland</u> B. COUNTY <u>Harford Co.</u> | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Bel Air</u> | | |
| | | D. STREET ADDRESS (If rural, give location) <u>62-32</u> <u>114 Eastern Avenue</u> | | |
| 5. SEX <u>Female</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED <u>Married</u> | 8. DATE OF BIRTH <u>Dec. 21, 1906</u> | 9. AGE (In years lost birthday) <u>60</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u> | | 11. BIRTHPLACE (State or foreign country) <u>Fallston, Harf. Co., Md.</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>John G. Gibson</u> | | |
| 14. MOTHER'S MAIDEN NAME <u>Mary Archer</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | |
| 16. SOCIAL SECURITY NO. <u>220-20-7890B</u> | | 17. INFORMANT (Husband) <u>838-3661</u> ADDRESS <u>Mr. Charles E. Blair</u> <u>114 Eastern Ave.</u> <u>Bel Air, Md. 21014</u> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>331X1</u> <u>Cerebral Hemorrhage</u> | | CAUSE OF DEATH (A) DUE TO <u>Cerebral Hemorrhage</u> (B) DUE TO <u>Cerebral Cerebral Anterior Cerebral</u> (C) DUE TO <u>Blindness</u> | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>no</u> |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (the hospital) attended the deceased from <u>Jan 3, 1966</u> to <u>Dec. 19, 1966</u> , that (I) last saw the deceased alive on <u>Dec. 18, 1966</u> and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE <u>Louis F. Klimes</u> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>12/19/66</u> |
| 23C. PHYSICIAN'S NAME (Type) <u>LOUIS F. KLIMES</u> | | 23D. ADDRESS <u>2623 E. Monument St.</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>Dec. 21, 1966</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Union Chapel Meth. Ch. Cem. Wilna, Harf. Co., Md.</u> |
| 24D. LOCATION <u>Bel Air, Md. 21014</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 23 1966</u> | | |
| 25B. NAME OF REGISTRAR <u>Joseph William Foster</u> | | 25C. FUNERAL DIRECTOR <u>W. Broadway & Williams</u> <u>Bel Air, Md. 21014</u> | | |

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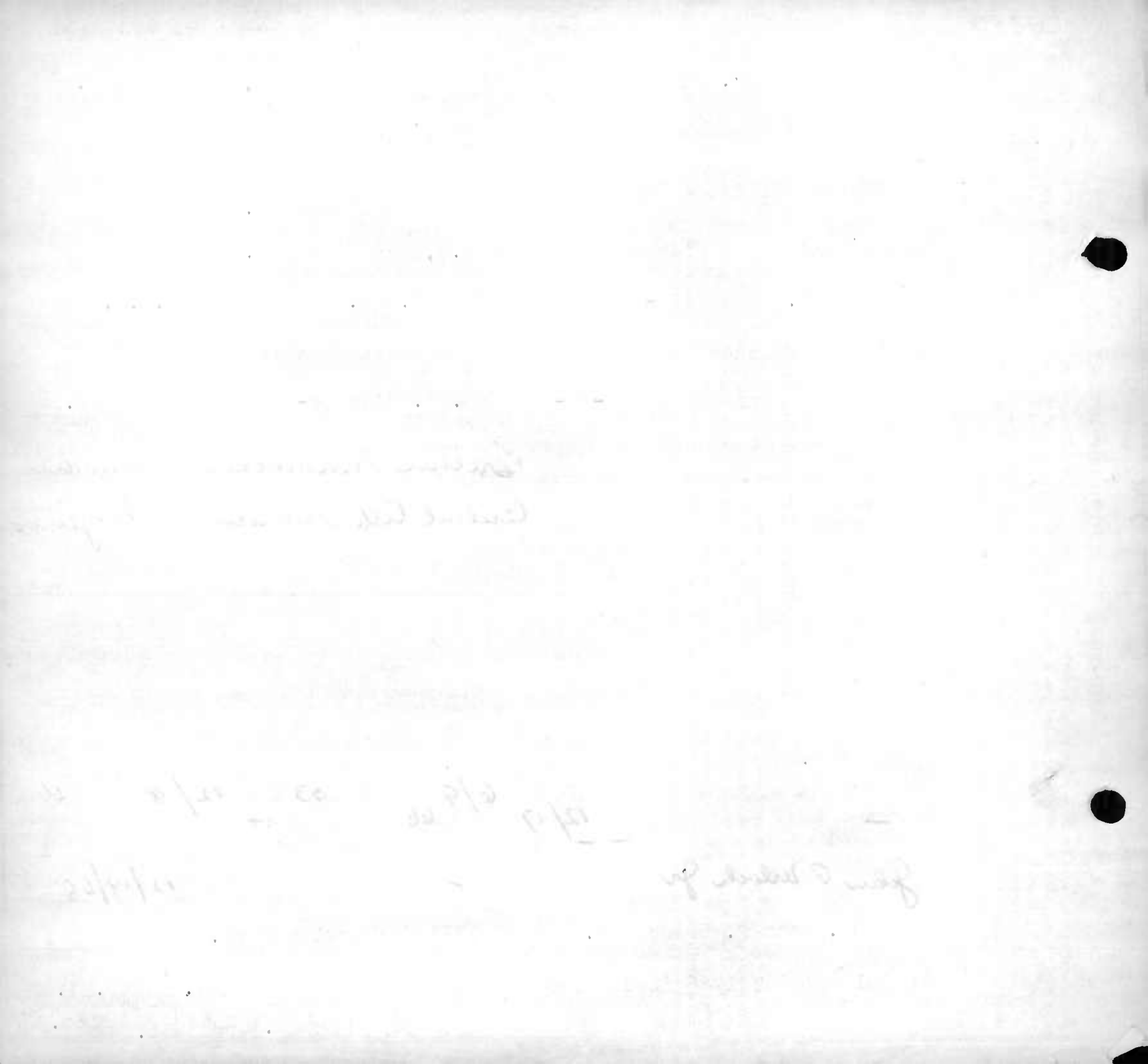
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|--|-------------------------|---|--|--|--|
| BIRTH NO. 66 12834 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12834 | |
| M.E. CASE NO. | | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) Elsie A. Fischer | | | 2. DATE AND HOUR OF DEATH December 18, 1966 3 A. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 43 South Baltimore General | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 21-02 D. STREET ADDRESS (If rural, give location) 1186 Nanticoke St. | | |
| 5. SEX female | 6. RACE white | 7. MARRIED, NEVER MARRIED WIDOWED | 8. DATE OF BIRTH Feb. 5, 1883 | 9. AGE (In years last birthday) 83 yrs. | If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tavern Prop. | | 10B. KIND OF BUSINESS OR INDUSTRY Self-employed | | 11. BIRTHPLACE (State or foreign country) Balto. Md. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 13. FATHER'S NAME Christian Fischer | | |
| 14. MOTHER'S MAIDEN NAME Charlotte Heckle | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no none | | |
| 16. SOCIAL SECURITY NO. 219-30-7424 | | | 17. INFORMANT ADDRESS Wm. C. Fischer-1186 Nanticoke St. | | |
| 18. 332 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cerebral Thrombosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cerebral Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH sudden 11 years | | | 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 6/9 1963 to 12/18 1966 , that (I) was lost saw the deceased alive on 12/17 1966 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE John P. Urlock Jr. | | | 23B. DATE SIGNED 12/19/66 | | |
| 23C. PHYSICIAN'S NAME (Type) Dr. John P. Urlock Jr. | | | 23D. ADDRESS 1227 Washington Blvd. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/21/66 | | 24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Frederick Ave. Balto. Md. | | 25A. DATE REC'D BY HEALTH DEPT. DEC 23 1966 | | 25B. NAME OF REGISTRAR R. E. ... | |
| 25C. FUNERAL DIRECTOR SCHWEINBERG FUNERAL SERVICE | | 25D. ADDRESS 11126 W. Cross St. Balto. 30 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. <u>66 12835</u> | |
|--|-------------------------|--|-------------------------------------|--|---|---|--|
| BIRTH NO. <u>66 28203</u> | | M.E. CASE NO. <u>66 12835</u> | | 1. NAME OF DECEASED (Type or Print) <u>RICE BOY</u> | | 2. DATE AND HOUR OF DEATH <u>12-18-66</u> <u>10:10P</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>40 ST. AGNES HOSPITAL</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>ANNE ARUNDEL</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>GLEN BURNIE</u> D. STREET ADDRESS (If rural, give location) <u>7642 LINDA LEE DRIVE</u> | | | |
| 5. SEX <u>MALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>NEW BORN</u> | 8. DATE OF BIRTH <u>12-18-66</u> | 9. AGE (In years lost birthday) <u>2</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Infant</u> | | 11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>2</u> | |
| 13. FATHER'S NAME <u>ROBERT Rice</u> | | | | 14. MOTHER'S MAIDEN NAME <u>BEVERLY WINDER</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT ADDRESS <u>Robert Rice 7642 Linda Lee Dr.</u> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Immaturity</u> <u>Premature Separation of Placenta</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>DECEMBER 18 1966</u> to <u>DECEMBER 18 1966</u> , that (I) (we) last saw the deceased alive on <u>DECEMBER 18 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>D. Robert Giangrandi</u> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>Dec 19, 1966</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>B ROBERT GIAGRANDE</u> | | | | 23D. ADDRESS M.D. <u>ST. AGNES HOSPITAL CATON & WILKENS</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12/20/66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Frederick Ave. Balto. Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 23 1966</u> | | 25B. NAME OF REGISTRAR <u>R. E. Jones</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>KRAUSE FUNERAL HOME 1216 S. Charles</u> | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12836 | |
|--|-------------------------|---|--|--|---|
| BIRTH NO. 66 12836 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Sister Veronica Nagel | | | 2. DATE AND HOUR OF DEATH December 20, 1966 2:00 A. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 94 Villa St. Michael 4000 Forest Hill Road Baltimore, Maryland 21207 | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 28-41 | | |
| D. STREET ADDRESS (If rural, give location) 4000 Forest Hill Road | | | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married | 8. DATE OF BIRTH Feb. 10, 1896 | 9. AGE (In years last birthday) 70 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant | | 10B. KIND OF BUSINESS OR INDUSTRY Institution | 11. BIRTHPLACE (State or foreign country) Plymouth, Indiana | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. |
| 13. FATHER'S NAME George Nagel | | | 14. MOTHER'S MAIDEN NAME Dorothy Flachentrager | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 219-54-0651 | 17. INFORMANT Sister Andrea, 4000 Forest Hill Road | | |
| 18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Cardio-vascular collapse DUE TO (B) Arteriosclerosis DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH 2 days 40 years | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1926 to Dec 20 1966 , that (I) (we) last saw the deceased alive on 12/20/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE DAMIAN PALAGIA M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) Damian Palagia M.D. | | | | 23D. ADDRESS 3316 Frederick Ave. Baltimore 29 Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12/22/66 | | 24C. NAME OF CEMETERY or CREMATORY St Joseph's | |
| 24D. LOCATION (City, town, or county) (State) Emmitsburg, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 23 1966 | | 25B. NAME OF REGISTRAR D. E. H. E. E. E. | | 25C. FUNERAL DIRECTOR Stewart & Mowen Co. | |
| | | | | ADDRESS 108 W. North Av. City | |

1895

26th Nov 1895

Dear Sir

I have the honor

to acknowledge the receipt

of your letter of the 21st

inst. in relation to

the matter of

the proposed

amendment to

the bye-laws

of the Association

and in reply to

inform you that the same have been

considered by the Committee and it is their

recommendation that the proposed

amendment be adopted and that the

Association be authorized to

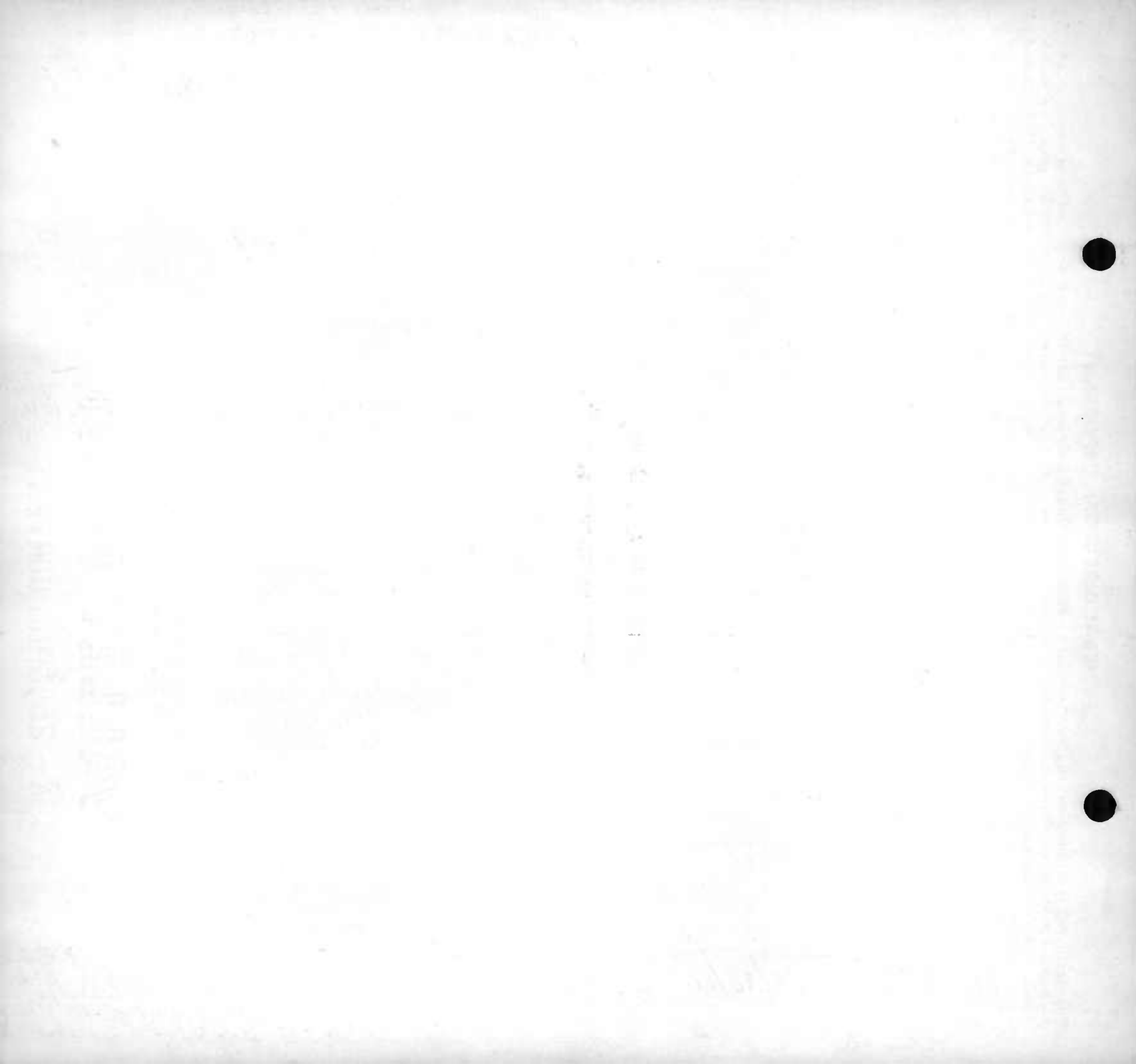
take such steps as may be necessary

Yours faithfully
J. H. [Signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. 66 12837 | | BALTIMORE CITY HEALTH DEPT. | | Registered No. 66 12837 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) PIAZZA, VINCENT S. | | 2. DATE AND HOUR OF DEATH 12-16-1966 6:25 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION THE UNION MEMORIAL HOSP 44 | | A. STATE MARYLAND B. COUNTY | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 9-04 | | | |
| | | D. STREET ADDRESS (If rural, give location) 2734 REESE STREET | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M | 8. DATE OF BIRTH 8-11-85 | 9. AGE (In years last birthday) 81 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKN | | 10B. KIND OF BUSINESS OR INDUSTRY Unk | | 11. BIRTHPLACE (State or foreign country) Italy | |
| 13. FATHER'S NAME JOSEPH PIAZZA | | 14. MOTHER'S MAIDEN NAME FORTUNA BEBILACQUA | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unk | | 16. SOCIAL SECURITY NO. Unk | | 17. INFORMANT Mrs. Josephina Matavea Putney Way | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 156.21 | | CAUSE OF DEATH Metastatic Liver Cancer | | INTERVAL BETWEEN ONSET AND DEATH Unk | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO Cachexia (B) DUE TO malnutrition (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | None | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED None | | 20A. AUTOPSY? (Yes or No) None | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) None | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) None | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) None | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? None | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-16-66 to 12-16-66, that (I) (we) last saw the deceased alive on 12-16-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Jeff Parker | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-16-66 | |
| 23C. PHYSICIAN'S NAME (Type) JEFF PARKER | | 23D. ADDRESS THE UNION MEMORIAL HOSP | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/20/66 | | 24C. NAME of CEMETERY or CREMATORY Meadow Ridge | |
| 24D. LOCATION (City, town, or county) Washington Blvd. Dorsey Rd. Baltimore, Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 23 1966 | | 25B. NAME OF REGISTRAR E. B. W. Johnson | | 25C. FUNERAL DIRECTOR 6306 - Belair Rd. Baltimore, Md. | |



Released on approval by Dr. Spitz of the Med. Exam. office to the hospital on 12/20/66

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | |
|---|--|-------------------------|--|---|---|------------------------------------|--|--|--|--|--|-----------------------------|--|--|
| BIRTH NO. 66 12838 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 66 12838 | | | | |
| 1. NAME OF DECEASED (Type or Print) Willis, Royce | | | | | 2. DATE AND HOUR OF DEATH 12/19/66 8:00 PM | | | | | M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL 33 | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND C. CITY OR TOWN (If outside city limits, write RURAL and give township) OXFORD D. STREET ADDRESS (If rural, give location) Rt 1 | | | | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) 2nd St. G. 70-00 | | | | |
| 5. SEX MALE | | 6. RACE WHITE | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE | | 8. DATE OF BIRTH 6-18-92 | | 9. AGE (In years last birthday) 74 | | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Caretaker | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | | 11. BIRTHPLACE (State or foreign country) Maryland | | | | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | 13. FATHER'S NAME GEORGE WILLIS | | | | | 14. MOTHER'S MAIDEN NAME LANA LINDON | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | | | | 16. SOCIAL SECURITY NO. 214-32-2381 | | | | | 17. INFORMANT Ronald H. Morris, Oxford, Md. | | | | |
| 18. 431X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Hemorrhage | | | | | CAUSE OF DEATH (A) DUE TO Rupture of Abdominal aortic aneurysm (B) DUE TO Ventricular Fibrillation (C) | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 12/19/66 | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured aneurysm | | | | | 20A. AUTOPSY? (Yes or No) No | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/> | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/19 1966 to 12/19 1966 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 23A. SIGNATURE Richard G. Parry | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | | 23B. DATE SIGNED 12/19/66 | | | | |
| 23C. PHYSICIAN'S NAME (Type) RICHARD G. PARRY | | | | | 23D. ADDRESS M.D. | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | | 24B. DATE 12/22/1966 | | | | | 24C. NAME OF CEMETERY or CREMATORY Oxford | | | | |
| 24D. LOCATION Oxford, Md | | | | | 25A. DATE REC'D BY HEALTH DEPT. | | | | | 25B. NAME OF REGISTRAR MAURICE E. NEUNAM & SON, Easton, Md. | | | | |
| 25C. FUNERAL DIRECTOR MAURICE E. NEUNAM & SON, Easton, Md. | | | | | 25D. ADDRESS | | | | | | | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 12839 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12839 | |
|---|-------------------------|---|---|---|---|---|---|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <i>John Herman Bruns</i> | | | | 2. DATE AND HOUR OF DEATH <i>Dec. 19, 1966</i> <i>5:50 P.</i> M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>00 4614 Marx Avenue</i> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>2602</i> D. STREET ADDRESS (If rural, give location) <i>4614 Marx Avenue</i> | | | |
| 5. SEX <i>Male</i> | 6. RACE <i>White</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <i>Married</i> | 8. DATE OF BIRTH <i>July 4, 1915</i> | 9. AGE (In years last birthday) <i>51</i> | If Under 1 Yr. Months | If Under 24 Hrs. Days | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ink Salesman</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Kohl & Maddox</i> | | 11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> |
| 13. FATHER'S NAME <i>Herman J. Bruns</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Mary Auer</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes WWII</i> | | | 16. SOCIAL SECURITY NO. <i>215-01-3315</i> | | 17. INFORMANT ADDRESS <i>Madeline M. Bruns - 4614 Marx Ave.</i> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) DUE TO <i>Widespread bony metastases</i> (B) DUE TO <i>Bronchiogenic carcinoma</i> (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH <i>2 months</i> <i>4 months</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION <i>10/6/66</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Pathologic fracture - hip</i> | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>8/20</i> 19 <i>66</i> to <i>12/19</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>12/19</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Robert R. Halthaus</i> | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>12/19/66</i> | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS M.D. <i>6208 Rodeshe Ave.</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12-22-66</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Baltimore National Cemetery</i> | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR <i>John C. Miller</i> | | 25C. FUNERAL DIRECTOR <i>John C. Miller Inc-6415 Belair Road-21206</i> | | ADDRESS | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|--|--|--|---|
| BIRTH NO. 66 12840 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12840 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | 735/1 M. | |
| 1. NAME OF DECEASED (Type or Print) WILLIAM C. MOORE | | | 2. DATE AND HOUR OF DEATH 12/19/66 | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTO. | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 2526 MADISON AVE. | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. | | |
| | | | D. STREET ADDRESS (If rural, give location) 2526 MADISON AVE | | |
| 5. SEX M | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 10/2/99 | 9. AGE (In years last birthday) 67 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (RETIRED) CHAUFFEUR | | | 10B. KIND OF BUSINESS OR INDUSTRY TELEPHONE CO. | | |
| 11. BIRTHPLACE (State or foreign country) U.A. | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME CORBIN MOORE | | | 14. MOTHER'S MAIDEN NAME MINNIE NELSON | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 212 05 0516 | | |
| 17. INFORMANT ESTELLA MOORE | | | ADDRESS 2526 MADISON AVE | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ASCVD | | | INTERVAL BETWEEN ONSET AND DEATH 5 yrs. | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arthritis | | | INTERVAL BETWEEN ONSET AND DEATH 11 yrs. | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4-25 19 55 to 12-19 19 66 , that (I) (we) last saw the deceased alive on 12-18 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Percival C. Smith | | | | 23B. DATE SIGNED 12-22-66 | |
| 23C. PHYSICIAN'S NAME (Type) Percival C. Smith | | | | 23D. ADDRESS 1709 Gwynns Falls Hwy | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/23/66 | | 24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. PK. | |
| 24D. LOCATION (City, town, or county) (State) Balto. Md. | | 25A. DATE REC'D BY HEALTH DEPT. DEC 23 1966 | | 25B. NAME OF REGISTRAR Wm. J. Chatman | |
| 25C. FUNERAL DIRECTOR Wm. J. Chatman | | ADDRESS p-1701 M.E. Cullen St | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | 66 12841 | | BALTIMORE HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. | | 66 12841 | |
|---|---------------------|--|--|--|----------------------------|--|-----------------------------|----------------|---|----------|--|
| 1. NAME OF DECEASED (Type or Print) ELBERT F. RITTER | | | | | | 2. DATE AND HOUR OF DEATH DEC. 19, 1966 6 30 P.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL 38 | | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 19-04 D. STREET ADDRESS (If rural, give location) 110 S. FULTON AVE. 23 | | | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWER | 8. DATE OF BIRTH 11/22/1886 | 9. AGE (In years lost birthday) 80 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Adjuster | | | 10B. KIND OF BUSINESS OR INDUSTRY Retired from HOME INSURANCE Co. Maryland | | | 11. BIRTHPLACE (State or foreign country) Maryland | | | 12. CITIZEN OF WHAT COUNTRY? U.S. A | | |
| 13. FATHER'S NAME James Ritter | | | | | | 14. MOTHER'S M maiden NAME Annie Osmond | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 216-05-9678 | | | 17. INFORMANT ADDRESS Anna Ackers 1903 E. 31st St. #18 | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) MYOCARDIAL INFARCTION 1 DAY CORONARY ARTERY DISEASE | | | | | | CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| 18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II | | | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that 2 (this hospital) attended the deceased from Dec 18, 1966 to Dec 19, 1966 , that we last saw the deceased alive on Dec 19, 1966 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. 2 (We) (did) not view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE John D. Pratt | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED 12/19/66 | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | | 23D. ADDRESS M.D. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 24B. DATE 12/22/66 | | | 24C. NAME of CEMETERY or CREMATORY Western Cemetery | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 23 1966 | | | 25B. NAME OF REGISTRAR John D. Pratt | | | 25C. FUNERAL DIRECTOR Walters Funeral Home Pratt & Stricker Sts. | | | ADDRESS | | |

WATSON-GLYCELABORATORY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. 66 12842 | | CERTIFICATE OF DEATH | | Registered No. 66 12842 | |
|---|-------------------------|---|--|--|--|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) <u>BLANCHE C. WEATHERSTEIN (WEATHERSTEIN)</u> | | | | 2. DATE AND HOUR OF DEATH <u>12/19/66</u> <u>11:00 A.M.</u> | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <u>33</u> (If not in hospital or institution, give street address or location) | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Balto. Co.</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Whitemarsh</u> D. STREET ADDRESS (If rural, give location) <u>53-00</u> <u>981A Lorley Beach Road</u> | | | | | |
| 5. SEX <u>FEMALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Single</u> | | 8. DATE OF BIRTH <u>11/4/48</u> | 9. AGE (In years lost birthday) <u>18</u> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STUDENT</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>SCHOOL</u> | | 11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John Weatherstein, JR.</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Stella Horwath</u> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT <u>JOHN WEATHERSTEIN</u> | | ADDRESS <u>SAME</u> | |
| 18. <u>556X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) <u>Cardiac arrest</u> DUE TO (B) <u>increased intracranial pressure</u> DUE TO (C) <u>CNS mass lesion</u> | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12/14</u> <u>1966</u> to <u>12/19</u> <u>1966</u> , that (I) (we) last saw the deceased alive on <u>12/19</u> <u>1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>Kenneth J. Bringham</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED <u>12/19</u> | | | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>Kenneth Bringham</u> | | | | 23D. ADDRESS M.D. <u>The Johns Hopkins Hospital</u> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>12-22-66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>SACRED HEART CEM.</u> | | 24D. LOCATION (City, town, or county) (State) <u>7401 GERMAN HILL RD. BALTO., CO., MD.</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 23 1966</u> | | 25B. NAME OF REGISTRAR <u>Robert E. ...</u> | | 25C. FUNERAL DIRECTOR <u>Charles S. Jolley</u> ADDRESS <u>9015 CONKLING ST. BALTO., 21224, MD.</u> | | | | | |

8

THE STATE OF

NEW YORK

IN SENATE

January 1, 1900

REPORT

OF

THE COMMISSIONERS OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE
JANUARY 1, 1900

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 12843 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12843 | |
|--|-----------------------------|--|--|--|--|---|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) George Louis Rather | | | | 2. DATE AND HOUR OF DEATH 12/17/66 12 45 AM | | M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital | | (If not in hospital or institution, give street address or location) | | A. STATE Maryland | | B. COUNTY A. A. Co. | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore Ventnor, A. 52-00 | | | |
| | | | | D. STREET ADDRESS (If rural, give location) Rt. #1 Box 126A | | | |
| 5. SEX M | 6. RACE Caucasian | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 10/1/03 | 9. AGE (In years last birthday) 63 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Filling Station Attendant | | | 10B. KIND OF BUSINESS OR INDUSTRY Hess Oil Co. | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME George E. Rather | | | | 14. MOTHER'S MAIDEN NAME Laura Mathews | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 216-05-2427 | | 17. INFORMANT Helen Towner | |
| | | | | ADDRESS 1415 Webster St. Balto | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebrovascular Accident 2 weeks | | | | (A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Generalized Atherosclerosis | | | | (B) DUE TO | | | |
| | | | | (C) Hypertension | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec. 10 1966 to Dec. 17 1966 , that (I) (we) last saw the deceased alive on Dec. 16 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Danfor, M.D. | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-18-1966 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Delfin Santos | | | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-20-1966 | | 24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 23 1966 | | 25B. NAME OF REGISTRAR Robert E. Santos | | 25C. FUNERAL DIRECTOR George J. Gonce-4001 Ritchie Hwy., Baltimore | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 12844 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12844 | |
|--|--|---|--|--|--|--|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| | | | | Marie Elizabeth Weber | | Dec. 19, 1966 11:10 A. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | |
| 90 Ardleigh Nursing Home 2095 Rockrose Ave. Baltimore, Md. | | | | Maryland Baltimore Balt. Co. | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | | | Owings Mills 53-00 | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | | |
| | | | | 25 Byway Road | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | |
| Female | | White | | Never Married | | 2/6/91 | |
| 9. AGE (in years lost birthday) | | 10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 75 | | Retired Laundry Worker | | | | Baltimore, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | 13. FATHER'S NAME | | | |
| U.S.A. | | | | Joseph Weber | | | |
| 14. MOTHER'S MAIDEN NAME | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| Mary Berndt | | | | No | | | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | | | |
| 218-22-3913 | | | | Mrs. Mary Rose Mills, Byway Rd. Owings Mills, Md. | | | |
| 18. 422.11 CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | 5 yrs. | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) Arteriosclerotic cardiovascular disease | | | |
| ANTECEDENT CAUSES | | | | (B) Old cerebral vascular | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | accident with partial paralysis (left side) | | | |
| II | | | | 15 yrs. | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | Epilepsy | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 0 | | | | No | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from November 8, 1966 to December 19, 1966, that (I) (we) last saw the deceased alive on December 18, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| Lloyd E. Saylor M.D. Attending Phys. <input checked="" type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 12/19/1966 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| Lloyd E. Saylor M.D. | | | | 3902 Greenmount Avenue | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 12/22/66 | | Baltimore, Cemetery | | Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| DEC 23 1966 | | H. J. Eckhardt | | Owings Mills, Md. | | | |

BIRTH NO. 66 12845 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12845

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

EDWARD R. BITTINGS

2. DATE AND HOUR PRONOUNCED DEAD

December 15, 1966 9:40 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

33 Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2015 E. Pratt Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)
Never Married

8. DATE OF BIRTH

Dec 28 1937

9. AGE (In years
last birthday)

28

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Service Station

10B. KIND OF BUSINESS OR INDUSTRY

Gas Station

11. BIRTHPLACE (State or foreign country)

Baltimore, Md

12. CITIZEN OF
WHAT COUNTRY?
U S A

13. FATHER'S NAME

Joseph J. Bittings

14. MOTHER'S MAIDEN NAME

Bernardine ZUZINSKI

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Joseph J. Bittings 2015 E Pratt Street

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Gunshot wound of head
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

2015 E. Pratt Street

21D TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
12-13-66 8:55 P.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot self in head

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

December 16, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Dec 19 1966

23C. NAME of CEMETERY or CREMATORY

St Matthew's Cemetery

23D. LOCATION

(City, town, or county)

O'Donnell Street

(State)

Md

24A. DATE REC'D BY HEALTH DEPT.

DEC 23 1966

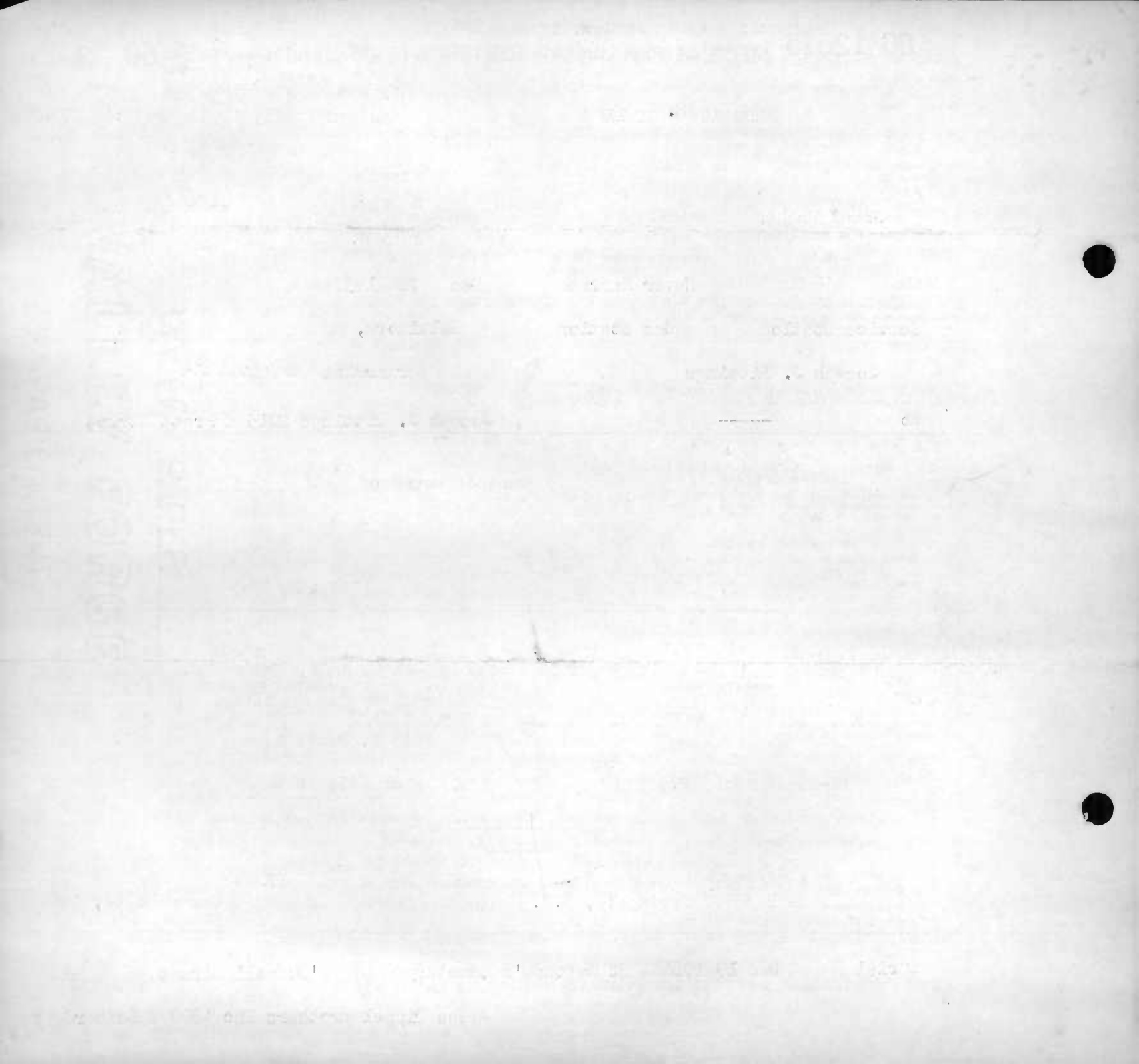
24B. NAME OF REGISTRAR

J. E. Springate

24C. FUNERAL DIRECTOR

ADDRESS

The Dippel Brothers Inc 1800 E Lombard St



1
W-300

66 12846

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12846

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Robert A. White

2. DATE AND HOUR PRONOUNCED DEAD

12/20/66 12:15 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

31

City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6707 Danville Ave.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Feb. 15, 1903

9. AGE (In years
last birthday)

63 X67

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Clerk

10B. KIND OF BUSINESS OR INDUSTRY

Railroad

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Fred White

14. MOTHER'S MAIDEN NAME

Rose Gibbons

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Evelyn M. White, 6707 Danville Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Arteriosclerotic cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D. ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/20/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/23/66

23C. NAME of CEMETERY or CREMATORY

Oak Lawn Cemetery

23D. LOCATION

(City, town, or county)

(State)

Colgate, Md.

24A. DATE REC'D BY HEALTH DEPT.

DEC 23 1966

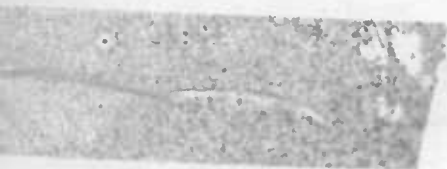
24B. NAME OF REGISTRAR

Robert E. Feltz

24C. FUNERAL DIRECTOR

Ullrich Funeral Home Dundalk, Md.

ADDRESS



VALLEY PAPER
MILL & LOGGING

CO. BAYVIEW



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | Registered No. 66 12847 | |
|--|---------------------------|---|---------------------------------|--|---|
| BIRTH NO. 66 12847 | | CERTIFICATE OF DEATH | | Registered No. 66 12847 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Thurston, Roy</u> | | 2. DATE AND HOUR OF DEATH <u>12/18/66</u> <u>8: P.M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE <u>md</u> B. COUNTY <u>Balto.</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Balto md</u> <u>53-00</u> | |
| 48 <u>Maryland General Hospital</u> | | D. STREET ADDRESS (If rural, give location) <u>2203 Sparrow Point Rd</u> | | | |
| 5. SEX <u>m</u> | 6. RACE <u>w</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>3/17/02</u> | 9. AGE (In years last birthday) <u>64</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tamitor</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>BUILDING</u> | | 11. BIRTHPLACE (State or foreign country) <u>Va</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | | 13. FATHER'S NAME <u>Edward Thurston</u> | | 14. MOTHER'S MAIDEN NAME <u>Lilla Smith</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>NO.</u> | | 16. SOCIAL SECURITY NO. <u>173-07-4756</u> | | 17. INFORMANT <u>Chart</u> ADDRESS <u>/</u> | |
| 18. <u>420.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) <u>myocardial infarct</u> DUE TO | | | |
| ANTECEDENT CAUSES | | (B) <u>arteriosclerotic heart disease</u> DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) <u>/</u> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | <u>gout</u> | | <u>Renal lithiasis</u> | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indefinite medical examination) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from <u>12/7</u> 19 <u>66</u> to <u>12/18</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12/18</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <u>Daniel C. Wilkerson</u> M.D. | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>12/18/66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Daniel C. Wilkerson</u> M.D. | | 23D. ADDRESS <u>421 Regester ave</u> <u>Balto md</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 24B. DATE <u>12/21/66</u> | 24C. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN CEMETERY</u> | | 24D. LOCATION (City, town, or county) <u>COLGATE MD</u> (State) <u>MD</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 23 1966</u> | | 25B. NAME OF REGISTRAR <u>ROSE E. Jones</u> | | 25C. FUNERAL DIRECTOR <u>ULLRICH FUNERAL HOME - DUNDALK MD</u> ADDRESS <u>/</u> | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | | |
|---|--|-------------------------|--|--|---|--|--|--|--|---|--|------------------------------|--|--|--|--|
| BIRTH NO. 66 12848 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 66 12848 | | | | | | |
| 1. NAME OF DECEASED (Type or Print) THOMAS REED DEWEY | | | | | 2. DATE AND HOUR OF DEATH 19 Dec 1966 10¹⁵ P.M. | | | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) University of Maryland Hospital | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY A.A.C. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Crofton D. STREET ADDRESS (If rural, give location) 1532 Endsley Place | | | | | | | | | | | |
| 5. SEX Male | | 6. RACE White | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | | 8. DATE OF BIRTH 17 Nov 1930 | | 9. AGE (In years last birthday) 36 | | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electronic Engineer | | | | | 10B. KIND OF BUSINESS OR INDUSTRY Nat'l Security Agency | | | | | 11. BIRTHPLACE (State or foreign country) Michigan | | | | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Thomas A. Dewey | | | | | 14. MOTHER'S MAIDEN NAME Elma Lage | | | | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II Korean | | | | | 16. SOCIAL SECURITY NO. | | | | | 17. INFORMANT Wife | | | | | ADDRESS S/A/H. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 1930 I | | | | | CAUSE OF DEATH (A) Astrocystoma, Gr III DUE TO (B) _____ DUE TO (C) _____ | | | | | INTERVAL BETWEEN ONSET AND DEATH 11 mo. | | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION 8 Dec 66 | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Recurrent brain tumor | | | | | 20A. AUTOPSY? (Yes or No) No | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 28 Nov 1966 to 19 Dec 1966 , that (1) (we) lost saw the deceased alive on 19 Dec 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | |
| 23A. SIGNATURE Robert S. Holt | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | | 23B. DATE SIGNED 19 Dec 66 | | | | | | |
| 23C. PHYSICIAN'S NAME (Type) Robert S. Holt | | | | | M.D. 23D. ADDRESS University Hospital | | | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | | 24B. DATE 2/27/66 | | | | | 24C. NAME of CEMETERY or CREMATORY Arlington Nat'l | | | | | 24D. LOCATION (City, town, or county) (State) VA. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 23 1966 | | | | | 25B. NAME OF REGISTRAR Robert S. Holt | | | | | 25C. FUNERAL DIRECTOR Robert S. Holt | | | | | ADDRESS Severna Park | |

15
100

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 12849</u> | |
|---|--|---|--|--|--|
| BIRTH NO. <u>66 12849</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. <u>1</u> | | | 1. NAME OF DECEASED (Type or Print) <u>IRENE TAYLOR</u> | | |
| 2. DATE AND HOUR OF DEATH <u>12/20/66</u> <u>12:45</u> <small>(A.M. or P.M.)</small> | | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>15-03</u> | | | 5. SEX <u>F</u> 6. RACE <u>N</u> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>SEP</u> | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE 2112 W. Wood Ave</u> | | | 8. DATE OF BIRTH <u>11/12/14</u> 9. AGE (In years (last birthday)) <u>52</u> | | |
| D. STREET ADDRESS (If rural, give location) <u>2107 Woodbrook Ave # 17</u> | | | 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COOK</u> | | |
| 11. BIRTHPLACE (State or foreign country) <u>MD</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 13. FATHER'S NAME <u>William Thomas</u> | | | 14. MOTHER'S MAIDEN NAME <u>Josephine Holland</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | 16. SOCIAL SECURITY NO. <u>220-12-9889</u> | | |
| 17. INFORMANT <u>Brother: MR. THOMAS HAMMOND</u> | | | ADDRESS | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) <u>CARCINOMA of STOMACH</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>19 months</u> | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>08/24/65</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>CARCINOMA of Stomach</u> | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12/19</u> <u>1966</u> to <u>12/20</u> <u>1966</u> , that (I) (we) last saw the deceased alive on <u>12/20</u> <u>1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Eduardo Hidalgo</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED <u>12/20/66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>EDUARDO HIDALGO</u> M.D. | | | | 23D. ADDRESS <u>Sinai Hospital</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12/23/66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>MT AUBURN</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>BALTIMORE</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR <u>John E. Taylor</u> | | 25C. FUNERAL DIRECTOR <u>Max Earl D'Angelo</u> (382) Cummer | |
| 25D. ADDRESS <u>ST</u> | | | | | |

2112 W. North Ave - since - 12-27-66

7807-51-026

Printed by the Bureau
Bureau of the Census

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------------|---|---|--|---|
| BIRTH NO. 66 12850 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12850 | |
| M.E. CASE NO. | | | 1. NAME OF DECEASED | | |
| 1. NAME OF DECEASED (Type or Print) COMEGYS, ARTHUR | | | 2. DATE AND HOUR OF DEATH 12/21/66 3:50 PM | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 46 LUTHERAN HOSPITAL OF MARYLAND | | | A. STATE MARYLAND | | |
| | | | B. COUNTY BALTIMORE | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) 16-08 | | |
| | | | D. STREET ADDRESS (If rural, give location) 793 GRANTLEY ST. | | |
| 5. SEX MALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SEP | 8. DATE OF BIRTH 10/12/13 | 9. AGE (In years lost birthday) 53 | II Under 1 Yr. Months: Days: II Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10B. KIND OF BUSINESS OR INDUSTRY Gen Contract | | 11. BIRTHPLACE (State or foreign country) Balt MD | |
| 13. FATHER'S NAME George Comegys | | | 14. MOTHER'S MAIDEN NAME Mary Johnson | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Harold Comegys 793 Grantley St | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | CAUSE OF DEATH (A) Acute Myocardial infarction | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) DUE TO | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | (C) DUE TO | | |
| 19A. DATE OF OPERATION 12/20/66 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from DEC 20 19 66 to DEC 21 19 66, that (I) (we) last saw the deceased alive on DEC 21 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Young Kil Kim M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED 12/21/66 | |
| 23C. PHYSICIAN'S NAME (Type) YOUNG KIL KIM M.D. | | | | 23D. ADDRESS LUTHERAN HOSPITAL OF MARYLAND | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/13/66 | | 24C. NAME OF CEMETERY or CREMATORY Mt Auburn | |
| 24D. LOCATION (City, town, or county) Baltimore | | 24E. STATE (State) MD | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 23 1966 | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| | | 25D. ADDRESS | | 25E. ADDRESS | |

George Condy
George Condy
George Condy

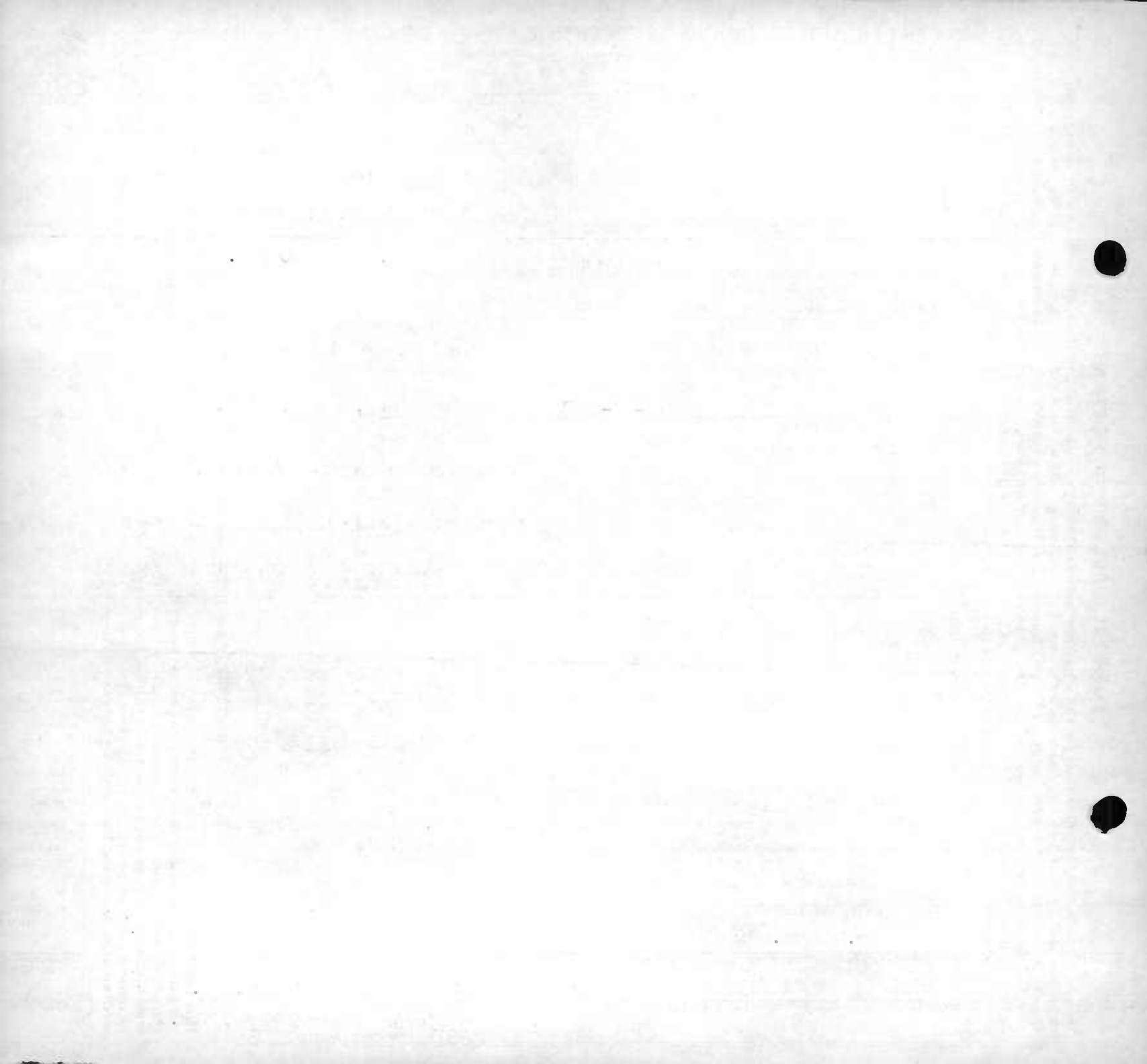
George Condy
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George Condy

George Condy
George Condy
George Condy

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 12851 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 66 12851 | | |
|--|---------------------|--|---|---|--|--|--|---|---------|--|
| 1. NAME OF DECEASED (Type or Print) JOSEPH F. HINKE | | | | 2. DATE AND HOUR OF DEATH 12-20-66 2:00 A.M. | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 37 MERCY HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3100 McELDERRY ST. #5 | | | | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 6-16-06 | 9. AGE (In years lost birthday) 60 yrs. | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GROCCER | | 10B. KIND OF BUSINESS OR INDUSTRY Self Employed | | 11. BIRTHPLACE (State or foreign country) BALTO. MD. | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME JOSEPH R. HINKE | | | | 14. MOTHER'S MAIDEN NAME MATILDA PAULSEN | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | | 16. SOCIAL SECURITY NO. 216-01-5991 | | 17. INFORMANT Louise Hinke, above, wife. | | | | ADDRESS | |
| 18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH | | | | (A) CEREBRAL VASCULAR ACCIDENT DUE TO | | | | INTERVAL BETWEEN ONSET AND DEATH 8 Days | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) HYPERTENSION DUE TO | | | | YRS. | | |
| | | | | (C) ARTERIOSCLEROTIC VASCULAR DISEASE | | | | YRS. | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-12-66 to 12-20-66 , that (I) (we) last saw the deceased alive on 12-19-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE Jay M. Barrash | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED 12-20-66 | | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Jay M. Barrash | | | | 23D. ADDRESS M.D. | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/23/66 | | 24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. | | | | ADDRESS 3331 Brehms Lane #13 | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|---------|--|---|---|--|--|--|
| 66 12852 | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 66 12852 | |
| BIRTH NO. | | | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| HOWARD HARRY FISHER | | | | Dec. 17, 1966 1 p. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 31 City Hospital | | | | A. STATE Md., 21224 | | | |
| | | | | B. COUNTY Balt. Co | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | | | Baltimore | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | D. STREET ADDRESS (If rural, give location) | | | |
| | | | | 711 50th Street | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | |
| male | white | married | 5/27/1909 | 57 | Tool Maker | | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | |
| Martin Co. | | | Baltimore, Md. | | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Frank Fisher, Sr. | | | | Henrietta (unknown) | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | | | Mary Melnick Fisher, wife, above | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 260 X I | | | | CORONARY OCCLUSION | | 1 HR | |
| ANTECEDENT CAUSES | | | | ARTERIOSCLEROTIC C.V.D. | | 3 yrs. | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | DIABETES | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 11/29/66 to 12/17/66, that (I) (we) last saw the deceased alive on 10/7/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| B. Highstein | | | | 12/20/66 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| Dr. Benjamin Highstein M.D. | | | | 121 S. Highland Ave. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 12/21/66 | | Oak Lawn Cemetery | | Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| DEC 23 1966 | | Robert E. Fisher | | Schimunek Funeral Home, Inc. | | 3331 Brehms Lane | |

GENERAL RECORDS
UNITED STATES
DISTRICT

1017 MAR 22 1917

1017010

0
A. H. H. H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 66-12853 | |
|---|---------------------|--|-------------------------------------|--|--|---|--|
| 1. NAME OF DECEASED (Type or Print) <i>Denwood Benton</i> | | | | 2. DATE AND HOUR OF DEATH 12/22/66 3:00 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>33 THE JOHNS HOPKINS HOSPITAL</i> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i> D. STREET ADDRESS (If rural, give location) <i>622 SOUTH PAYSON STREET</i> | | | |
| 5. SEX <i>M</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>MARRIED</i> | 8. DATE OF BIRTH <i>12/01/95</i> | 9. AGE (In years, last birthday) <i>71</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>SEATED SALESMAN</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>SUPER MARKET</i> | | 11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>SHELTON BENTON</i> | | | | 14. MOTHER'S MAIDEN NAME <i>L. Ly Messick</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>215-10-3509</i> | | 17. INFORMANT ADDRESS <i>Ed. L. Sanders 1922 RAMSAY ST.</i> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>527.21</i> | | | | CAUSE OF DEATH (A) <i>Cardiac arrest</i> DUE TO (B) <i>Chronic lung disease & secondary</i> DUE TO (C) <i>Lung disease</i> | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>peripheral vascular insufficiency</i> | | | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>No</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work At <input type="checkbox"/> Work | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>12/19</i> to <i>12/22</i> 19 <i>66</i> , that (I) (we) lost saw the deceased alive on <i>12/22</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Kenneth L. Brigham</i> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>12/22/66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>KENNETH L. BRIGHAM</i> | | | | 23D. ADDRESS <i>Johns Hopkins Hospital</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 24B. DATE <i>12-24-66</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>WESTERN</i> | | 24D. LOCATION (City, town, or county) (State) <i>BALTIMORE, MD</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 23 1966</i> | | 25B. NAME OF REGISTRAR <i>Geo. L. Schuch</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>Geo. L. Schuch & Son, Inc. 2101 Frederick Ave.</i> | | | |

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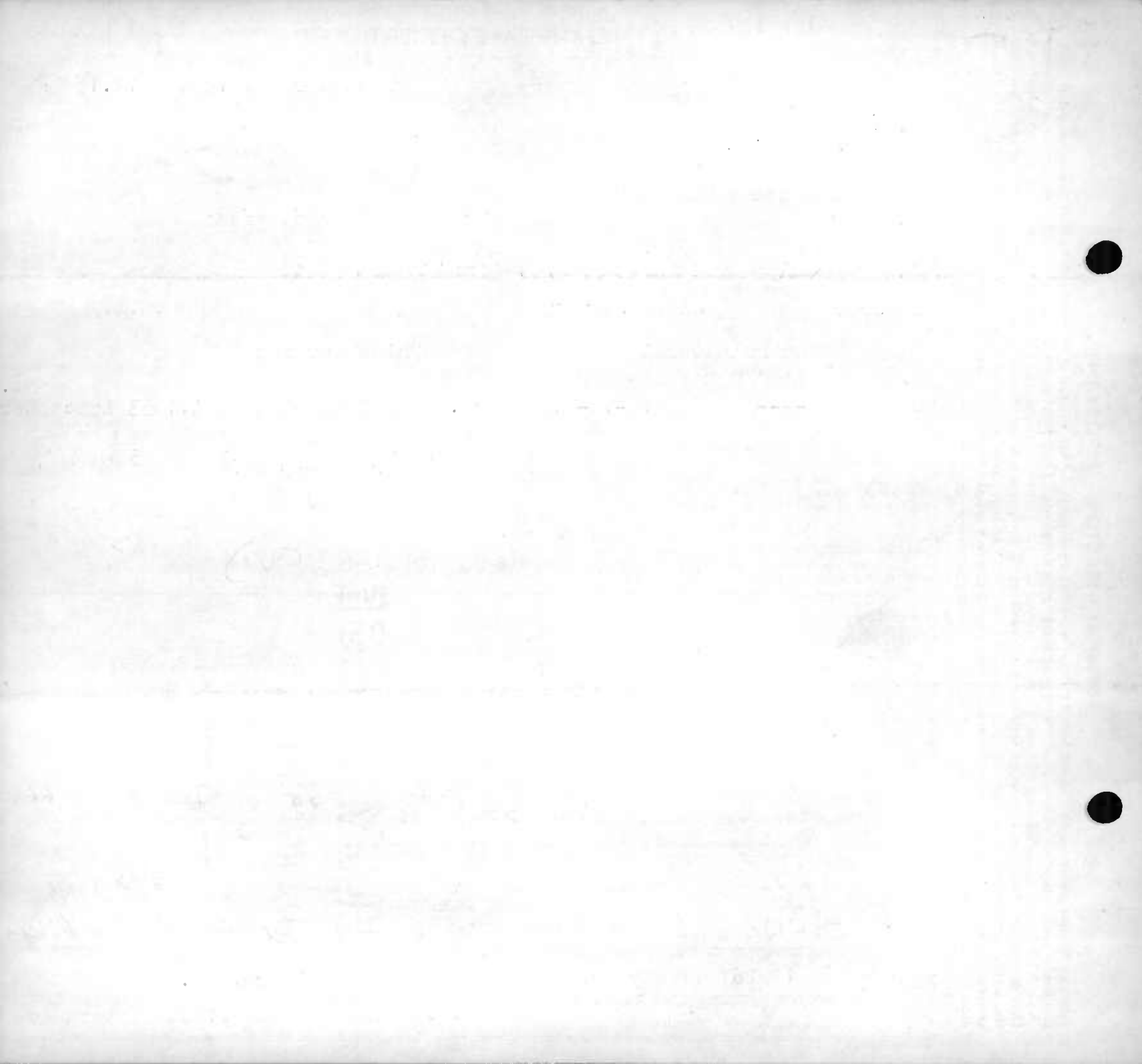
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|--|------------------|--|----------------------------|--|---|
| BIRTH NO. 66 12854 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12854 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) FRANK W. POLANOWSKI | | 2. DATE AND HOUR OF DEATH December 22, 1966 12.15 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 35 Church Home & Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 2-03 D. STREET ADDRESS (If rural, give location) 1633 Lancaster Street | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 2/3/12 | 9. AGE (In years last birthday) 54 | If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10B. KIND OF BUSINESS OR INDUSTRY Alloy Foundry | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Simon Polanowski | | 14. MOTHER'S MAIDEN NAME Josephine Barczak | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 215-14-9138 | | 17. INFORMANT ADDRESS Mrs. Josephine Polanowski, 1633 Lancaster St. | |
| 18. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH (A) Myocardial infarction DUE TO (B) old coronary DUE TO (C) arteriosclerotic CVD | | INTERVAL BETWEEN ONSET AND DEATH 15 min? 2 yrs ago ? | |
| MEDICAL CERTIFICATION | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Feb 19 58 to Dec 22 19 66, that (I) (we) last saw the deceased alive on Dec 22 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE B. V. Lock M.D. | | 23B. DATE SIGNED 12/23/66 | | | |
| 23C. PHYSICIAN'S NAME (Type) BURTON V. LOCK M.D. | | 23D. ADDRESS 2936 E Balto St Baltimore | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/26 | | 24C. NAME OF CEMETERY or CREMATORY Holy Rosary | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 23 1966 | | 25B. NAME OF REGISTRAR M.F. SADOWSKI | | 25C. FUNERAL DIRECTOR M.F. SADOWSKI & SONS, 1808 Eastern Ave | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---|------------------|--|----------------------------------|--|---|
| BIRTH NO. 66 12855 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12855 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | HAMILTON C. DUBREUIL | | 2. DATE AND HOUR OF DEATH December 20, 1966 5 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 00 2713 The Alameda | | (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore - 21218 | |
| | | D. STREET ADDRESS (If rural, give location) 2713 The Alameda | | 9-07 | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widower | 8. DATE OF BIRTH Apr. 3, 1885 | 9. AGE (In years last birthday) 81 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Business Agent Steam-fitters#438 | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Armand H. DuBreuil | | 14. MOTHER'S MAIDEN NAME Laura Virginia Bruner | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 218-03-2339 | | 17. INFORMANT ADDRESS Mrs. Ethel Royal-714 N. Chapelgate Lane | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 420, 1 I CORONARY THROMBOSIS & MYOCARDIAL INFARCTION ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Emphysema | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 10 minutes 20 years 30 years | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from May 19 66 to Dec 19 1966, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Thomas J. Brennan | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 21 Dec 1966 | |
| 23C. PHYSICIAN'S NAME (Type) Thomas J. Brennan | | 23D. ADDRESS 5217 Harford Road Balto Md 21214 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/24/66 | | 24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery | |
| 24D. LOCATION Baltimore, Maryland | | 24E. LOCATION (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 23 1966 | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS H. Sander & Sons, Inc., Baltimore, Md. | |

University of Washington
Department of Anthropology
Prehistoric Archaeology
East-Asian Studies Program

F. J. Beckwith

May 22 Dec 1952

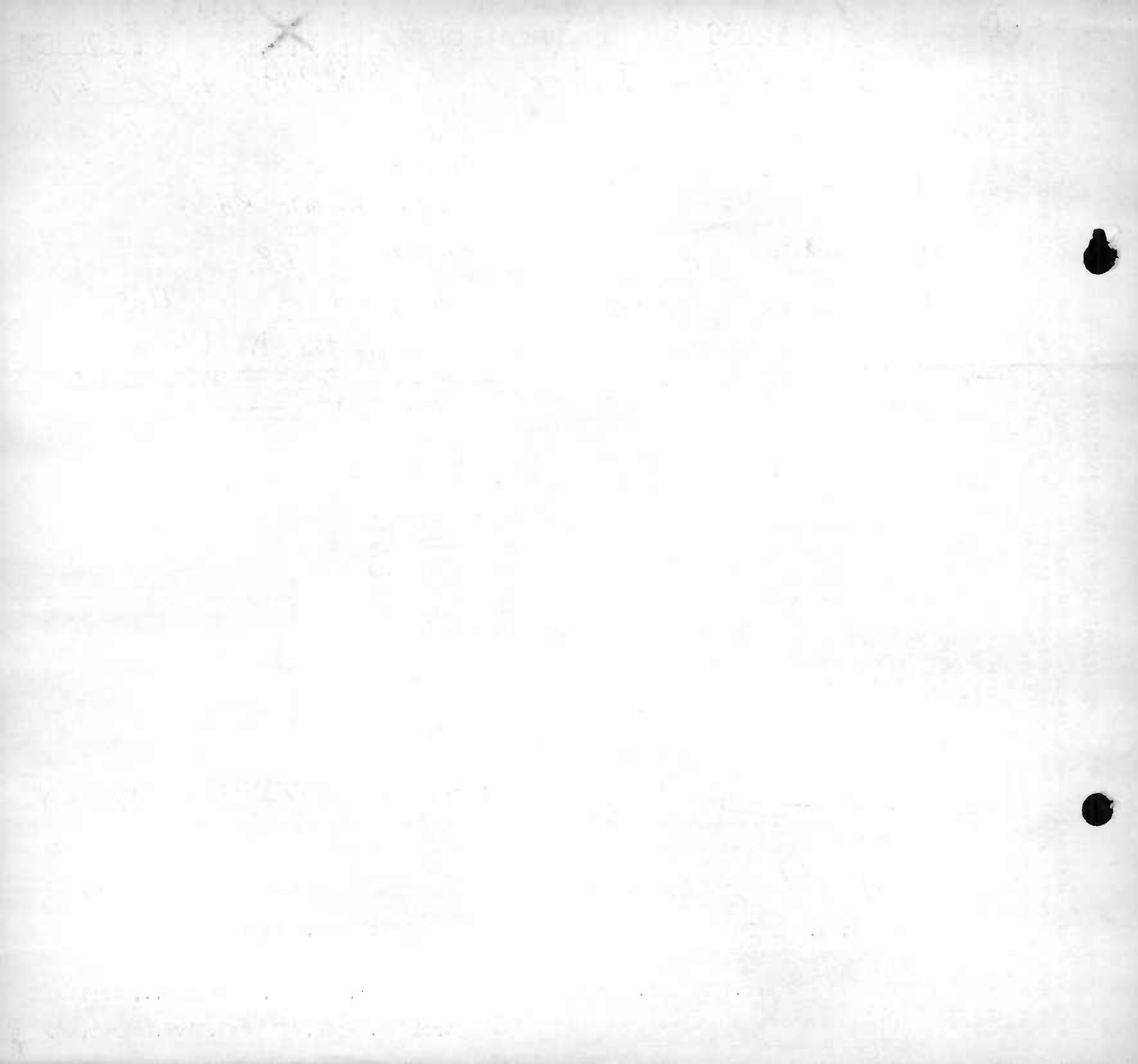
Thomas J. Harrison

✓
21 Dec 1952
5212 Stanford Road
Berkeley, California

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 12856 | | | | BALTIMORE CITY DEPARTMENT OF HEALTH CERTIFICATE OF DEATH | | | | IRVIN W. IRWIN W. 68 DR. Registered No. 3-405 DR. FINE 66 WDI 2856 | | | |
|--|-------------------------|---|------------------------------------|---|--|--|------------------------------|--|--|--|--|
| M.E. CASE NO. 32-2 | | | | 1. NAME OF DECEASED (Type or Print) Irvin William Iager | | | | 2. DATE AND HOUR OF DEATH Dec. 19, 1966 5 P. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Baltimore | | | | 5. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital | | | | 6. STREET ADDRESS (If rural, give location) 7638 Belair Rd. | | | | 7. ZIP CODE 33-00 | | | |
| 5. SEX Male | 6. RACE white | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) divorced | 8. DATE OF BIRTH 5/15/19 | 9. AGE (In years last birthday) 68 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Hours: Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farm work | | | | 10B. KIND OF BUSINESS OR INDUSTRY farming | | | | 11. BIRTHPLACE (State or foreign country) Maryland | | | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | | | 13. FATHER'S NAME Frederick William Iager | | | | 14. MOTHER'S MAIDEN NAME Margaritha Dinkleman | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | | | 16. SOCIAL SECURITY NO. 579-34-1157 | | | | 17. INFORMANT ADDRESS | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osihenio, etc. It means the disease, injury or complication which caused death.) Ca. of lung pneumonia | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Acromegaly | | | | | | | |
| 19A. DATE OF OPERATION none | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) yes | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec. 16, 1966 to Dec. 19, 1966 , that (I) (we) last saw the deceased alive on Dec. 19, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE A. M. Morris M.D. | | | | | | | | 23B. DATE SIGNED 12/19/66 | | | |
| 23C. PHYSICIAN'S NAME (Type) A. M. MORRIS | | | | | | | | 23D. ADDRESS Baltimore, Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | | 24B. DATE 22 Dec. 1966 | | | | 24C. NAME OF CEMETERY or CREMATORY St. SPauls Luthurn Church Cem, Fulton, Howard Co., Maryland | | | |
| 24D. LOCATION (City, town, or county) (State) | | | | 25A. DATE REC'D BY HEALTH DEPT. DEC 23 1966 | | | | 25B. NAME OF REGISTRAR Harold S. Wade | | | |
| 25C. FUNERAL DIRECTOR ADDRESS 550 Wash. Blvd. Laurel, Md. | | | | | | | | | | | |



BIRTH NO.

66 12857

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

66 12857

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Anna Sherman

2. DATE AND HOUR PRONOUNCED DEAD

12/19/66

9:40 p.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

44

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Virginia

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Woodstock

D. STREET ADDRESS (If rural, give location)

Rt. 2

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

4/28/08

9. AGE (In years
last birthday)

58

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Lee Peer

14. MOTHER'S MAIDEN NAME

Lula Smoot

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

N/A

17. INFORMANT

Harry Sherman, Sr.

ADDRESS

Woodstock, Va.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic and hypertensive cardio-
vascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/20/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/22/66

23C. NAME of CEMETERY or CREMATORY

Sunset View Memorial

23D. LOCATION

(City, town, or county)

(State)

Woodstock, Virginia

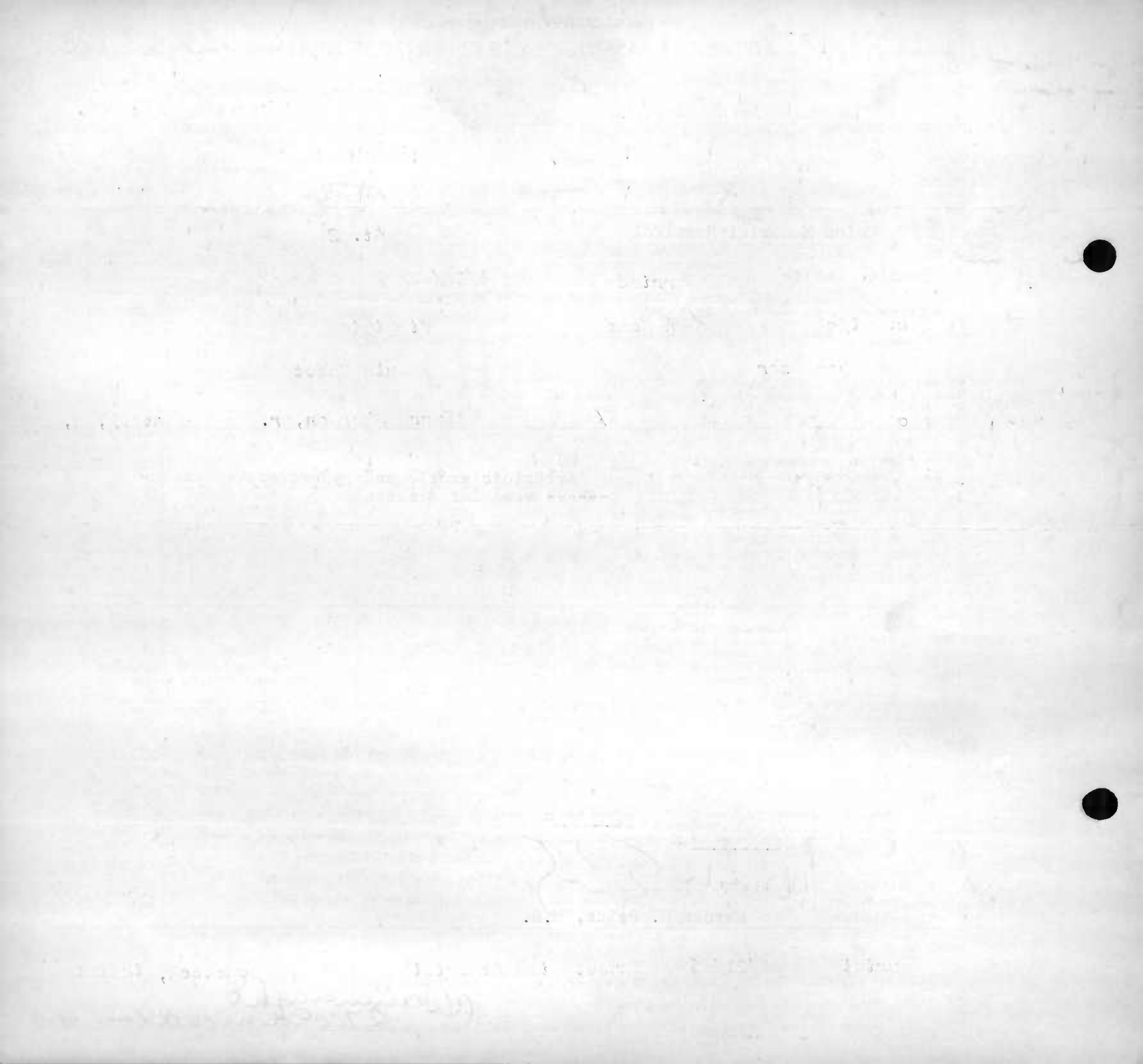
24A. DATE REC'D BY HEALTH DEPT.

DEC 23 1966

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

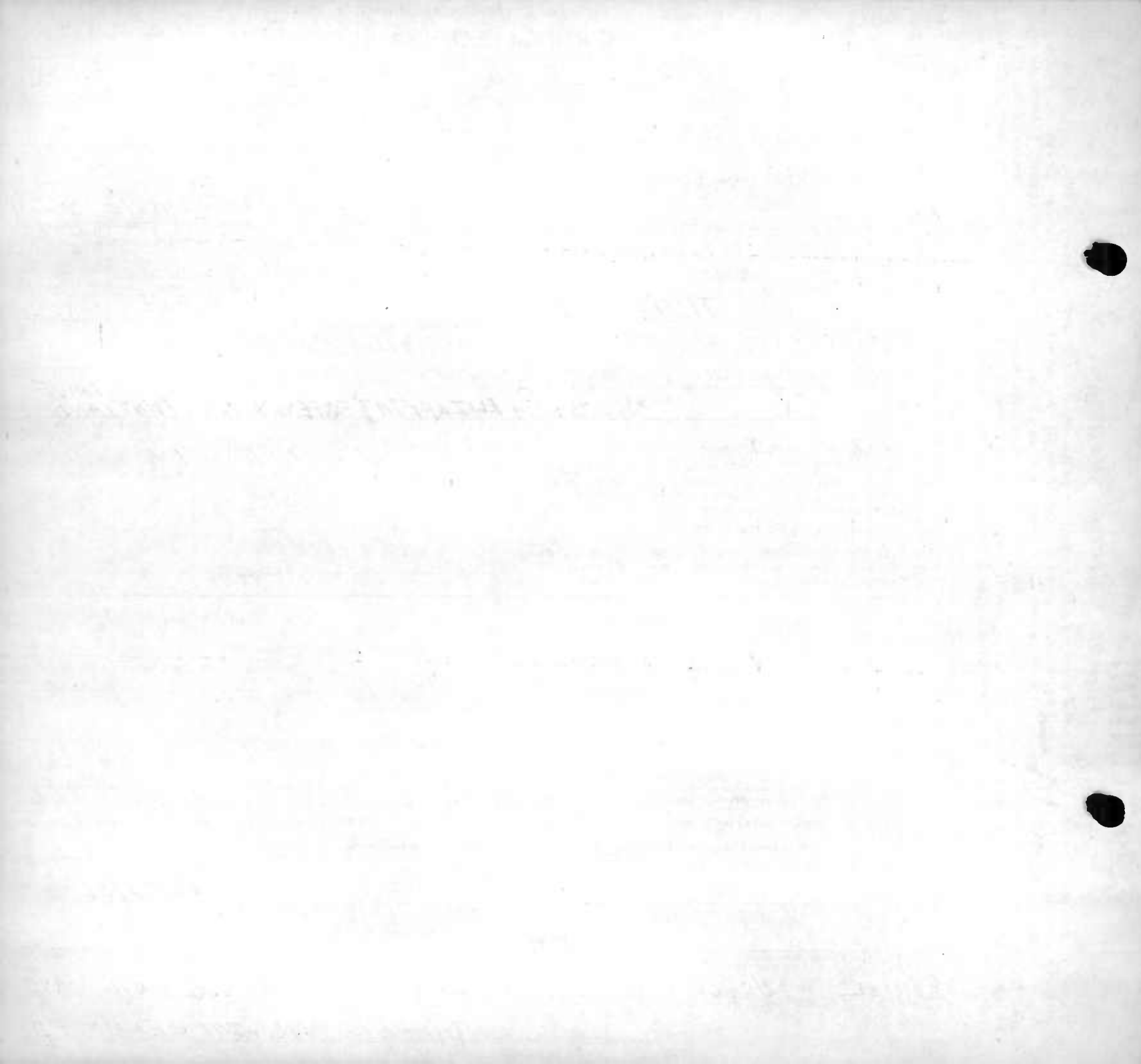
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|--|-------------------------------------|--|--|
| S 500 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12858 | |
| BIRTH NO. 66 12858 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) MR SWEENEY JOSEPH JOHN | | 2. DATE AND HOUR OF DEATH 21 DECEMBER 1966 748 PM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 27-07 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL BALTIMORE | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| D. STREET ADDRESS (If rural, give location) 2301 PENTLAND DRIVE 21234 | | | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 10-11-87 | 9. AGE (In years last birthday) 79 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | 10B. KIND OF BUSINESS OR INDUSTRY TELEPHONE CO. | | 11. BIRTHPLACE (State or foreign country) MARYLAND | 12. CITIZEN OF WHAT COUNTRY? AMERICAN USA |
| 13. FATHER'S NAME JOHN SWEENEY | | 14. MOTHER'S MAIDEN NAME ANNA CURLETT | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. A 212-03-6714 | | 17. INFORMANT ELIZABETH SWEENEY ADDRESS DRIVE 2301 PENTLAND | |
| 18. I 4 20 11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) MYOCARDIAL INFARCTION ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE | | CAUSE OF DEATH MYOCARDIAL INFARCTION | | INTERVAL BETWEEN ONSET AND DEATH SUDDEN 6 YEARS | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/21 635 PM '66 to 12/21 748 PM '66 , that (I) (we) last saw the deceased alive on 12/21 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Fridtjofur Bjornsson M.D. | | | | 23B. DATE SIGNED 12/21/66 | |
| 23C. PHYSICIAN'S NAME (Type) FRIDTJOFUR BJORNSSON | | | | 23D. ADDRESS UNION MEMORIAL HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12/24/66 | | 24C. NAME of CEMETERY or CREMATORY CATHEDRAL CEM. | |
| 24D. LOCATION (City, town, or county) (State) OLD FREDRICK RD BALTO, MD | | 25A. DATE REC'D BY HEALTH DEPT. DEC 23 1966 | | 25B. NAME OF REGISTRAR DIPPEL BROS | |
| 25C. FUNERAL DIRECTOR ADDRESS 2110 BELAIR RD | | | | | |



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L-153

66 12859

BALTIMORE CITY HEALTH DEPARTMENT

66 12859

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

THOMAS W. ~~LAVENDOR~~ Lavendor

2. DATE AND HOUR PRONOUNCED DEAD

December 18, 1966 2:20 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 621 N. Collington Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

621 N. Collington Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed

8. DATE OF BIRTH

Aug. 12, 1892

9. AGE (in years
last birthday)

55 74

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Boiler Maker

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Mississippi

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Joseph

Lavendor

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)
NO

16. SOCIAL SECURITY NO.
218-01-8205A

17. INFORMANT 6014 Eastern Ave.
Edward J. Lavendor, Baltimore, Maryland (24)

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Pulmonary emphysema

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.)

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

December 19, 1966

23A. ~~USUAL~~ CREMATION,
REMOVAL (Specify)
Cremation

23B. DATE

Dec. 23, 1966

23C. NAME of ~~DECEASED~~ or CREMATORY

Green Mount

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

DEC 22 1966

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

Wm. Cook-Brooks, Inc., 1217 St. Paul St.
Baltimore 2, Maryland

RECEIVED

WILLIAM POTTAGE

W. W. POTTAGE

Dec. 11, 1900

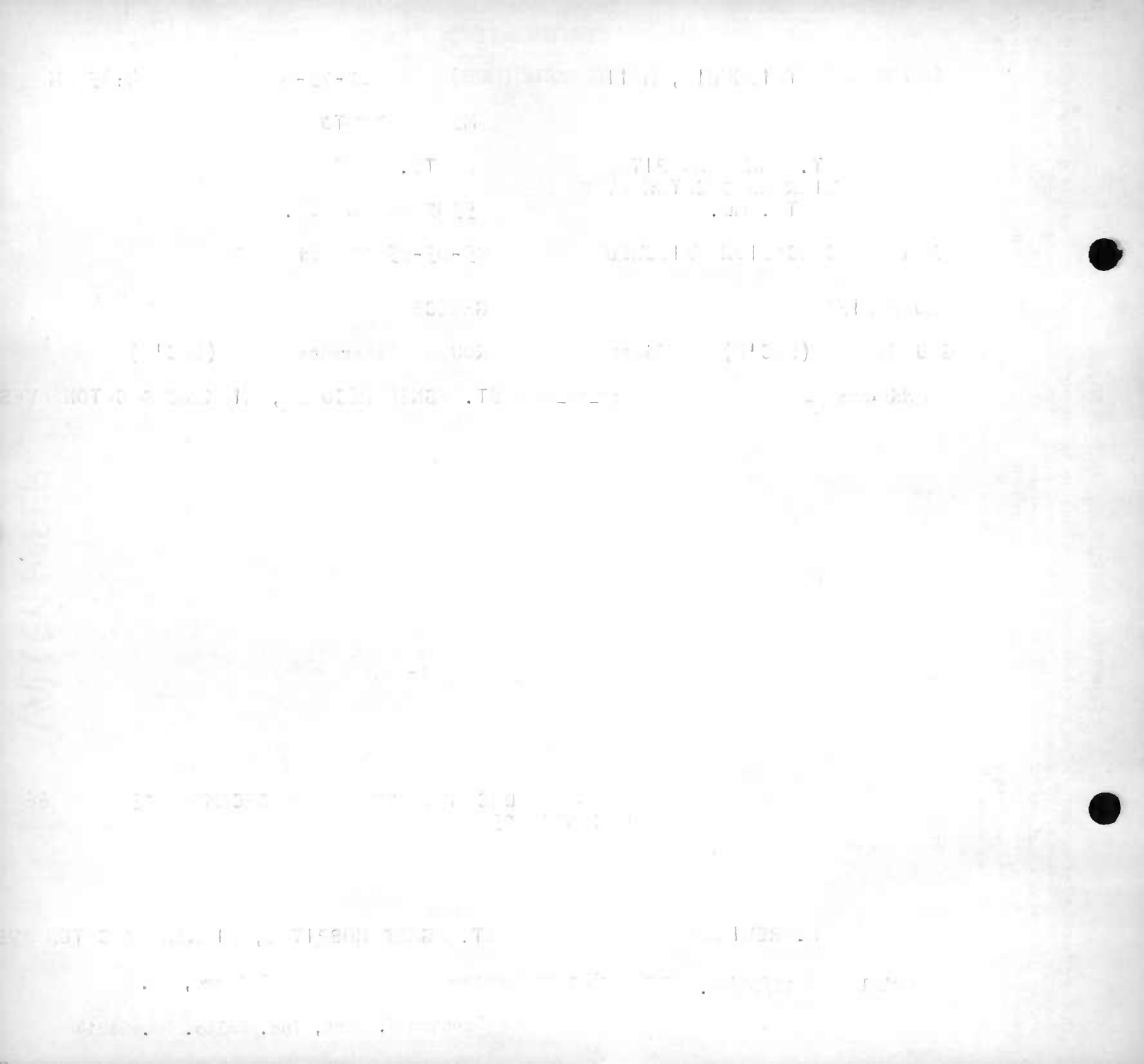
W. W. POTTAGE

W. W. POTTAGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-----------------------------|--|--|--|---|
| BIRTH NO. 66 12860 | | CERTIFICATE OF DEATH | | Registered No. 66 12860 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type in full name) TSIGOUNIS, MARIA (MARY) | | 2. DATE AND HOUR OF DEATH 12-23-66 4:45 AM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL WILKENS & CATON AVES BALTO. MD. | | A. STATE MD B. COUNTY BALTO | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. #14 | | | |
| | | D. STREET ADDRESS (If rural, give location) 5502 ALBAN AVE. | | | |
| 5. SEX FEMALE | 6. RACE CAUCASION | 7. MARRIED, NEVER MARRIED WIDOWED | 8. DATE OF BIRTH 05-05-25 03 | 9. AGE (In years last birthday) 61 63 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) GREECE | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME GEORGE (DEC'D) Klicos | | 14. MOTHER'S MAIDEN NAME KOULA Zaharades (DEC'D) | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN No | | 16. SOCIAL SECURITY NO. 218-18-8836D | | 17. INFORMANT ADDRESS ST. AGNES RECORDS, WILKENS & CATON AVES | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 3410 I | | CAUSE OF DEATH (A) <i>acute bleeding from perforated ulcer.</i> (B) <i>Duodenal peptic ulcer</i> (C) | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from DECEMBER 20 19 66 to DECEMBER 23 19 66 , that (I) (we) last saw the deceased alive on DECEMBER 23 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>R. Revilla</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-23-66 | |
| 23C. PHYSICIAN'S NAME (Type) R. REVILLA | | 23D. ADDRESS M.D. ST. AGNES HOSPITAL, WILKENS & CATON AVE | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/26/66 | | 24C. NAME of CEMETERY or CREMATORY Greek Orthodox Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | 25B. NAME OF REGISTRAR <i>Robert E. Johnson</i> | | 25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc. Balto. Md. 21214 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|-------------------------|---|---|--|---|--|---|--|--|
| 66 12861 | | | | | 66 12861 | | | | |
| BIRTH NO. | | | | | CERTIFICATE OF DEATH | | | | |
| M.E. CASE NO. | | | | | Registered No. | | | | |
| 1. NAME OF DECEASED (Type or Print) Elizabeth M. Burns | | | | | 2. DATE AND HOUR OF DEATH Dec. 22, 1966 5:15 A.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND 90 Harford Gardens Nursing Home | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Pennsylvania B. COUNTY Philadelphia C. CITY OR TOWN (If outside city limits, write RURAL and give township) V-35 D. STREET ADDRESS (If rural, give location) 1919 Walnut St. | | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH 2-8-94 | 9. AGE (In years lost birthday) 72 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME William Burns | | | | | 14. MOTHER'S MAIDEN NAME Brigid Stevens | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 182-05-1695 | | 17. INFORMANT Charlotte Hosier, 1524 Doxbury Rd. | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Metastatic carcinoma lungs and skeletal system | | | | | INTERVAL BETWEEN ONSET AND DEATH 17 months | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Carcinoma breast | | | | | 20 months | | | | |
| II | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 12 Sept 66 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Recurrent carcinoma | | | 20A. AUTOPSY (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 8 March 1965 to 22 December 1966 , that (I) was lost saw the deceased alive on 20 December 1966 and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) was (did) view view the body after death. | | | | | | | | | |
| 23A. SIGNATURE John W. Barnaby | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED 22 Dec 66 | |
| 23C. PHYSICIAN'S NAME (Type) JOHN W. BARNABY | | | | | 23D. ADDRESS M.D. 1531 E North Ave | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 24B. DATE 12-24-66 | | 24C. NAME of CEMETERY or CREMATORY New Cathedral | | 24D. LOCATION (City, town, or county) (State) Balto., Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | | 25B. NAME OF REGISTRAR Leonard J. Ruck, Inc. | | | 25C. FUNERAL DIRECTOR ADDRESS Balto. Md. 21214 | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|-------------------------|---|--|---|--|--|---|---|--|
| BIRTH NO. 66 12862 | | | | | CERTIFICATE OF DEATH | | | Registered No. 66 12862 | |
| 1. NAME OF DECEASED (Type or Print) <i>Ida B. Dawson</i> | | | | | 2. DATE AND HOUR OF DEATH <i>Dec. 22, 1966.</i> <i>1:15 A.M.</i> | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>96 Harford Gardens Nursing Home</i> | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>9-06</i> <i>2701 Fenwick Ave.</i> | | | | |
| 5. SEX <i>Female</i> | 6. RACE <i>White</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i> | | 8. DATE OF BIRTH <i>1-22-82</i> | 9. AGE (In years lost birthday) <i>34</i> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Balto., Md.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | |
| 13. FATHER'S NAME <i>John Cash</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Annie Ross</i> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>220-14-9031</i> | | 17. INFORMANT ADDRESS <i>Mrs. Howard S. Adams, 2824 Fleetwood Ave.</i> | | | | | |
| 18. <i>420.11</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH (A) <i>Coronary Thrombosis</i> DUE TO (B) <i>Arterio Sclerotic Cardio</i> DUE TO <i>Vascular Disease</i> | | | INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>20 months</i> | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>No</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Apr 27</i> 19 <i>65</i> to <i>Dec 22</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>Dec 21</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <i>Chas. Wm Edmunds</i> | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>Dec 22, 1966</i> | | |
| 23C. PHYSICIAN'S NAME (Type) <i>Chas. Wm Edmunds</i> | | | | 23D. ADDRESS <i>2746 Lee Alameda</i> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12-24-66</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Woodlawn</i> | | 24D. LOCATION (City, town, or county) (State) <i>Balto., Md.</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc.</i> | | ADDRESS <i>Balto. Md. 21214</i> | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------------|---|-------------------------|--|--|
| BIRTH NO. 66 12863 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12863 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) William F. FONTZ | | 2. DATE AND HOUR OF DEATH 12-22-66 1:35 P. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 43 South Baltimore General Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 24-04 D. STREET ADDRESS (If rural, give location) 1523 William Street | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widower-Married | 8. DATE OF BIRTH 2/3/95 | 9. AGE (In years last birthday) 71 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAILOR | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Balto. Md. | |
| 13. FATHER'S NAME William Fontz | | 14. MOTHER'S MAIDEN NAME Josephine Conway | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give wgt or dates of service) Yes | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Family - NAME ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 431 X 163 X | | CAUSE OF DEATH (A) MYOCARDIAL Infarction DUE TO (B) Abdominal Aortic Aneurysm DUE TO (C) Anteriorly located Cardio-Vascular Disease DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 10 hours. 1/2 year. 10 yrs. | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Carcinoma of Asthma - Chronic Emphysema. | | | |
| 19A. DATE OF OPERATION 12-15-66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Abdominal Aneurysm | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (H) (this hospital) attended the deceased from 12/14/66 19 to 12/22/66 19 that (H) (we) last saw the deceased alive on 12/22/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Beresford M. Swan M.D. | | 23B. DATE SIGNED 12/22/66 | | 23C. PHYSICIAN'S NAME (Type) Beresford M. Swan | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 12/27/66 | | 24C. NAME OF CEMETERY OR CREMATORY Balto. Hos. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR McCreary - 1306 Ford Ave. | |

street map, map, 11/12/12

2014-01-05

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2000-01-01

Environ Monit Assess (2008) 142:1–12

Summary

January 1991

دعا علیہ السلام

04/11/14

د. یوسف ابراهيم

1975/76

Received 14 August 2003

2-10-1947

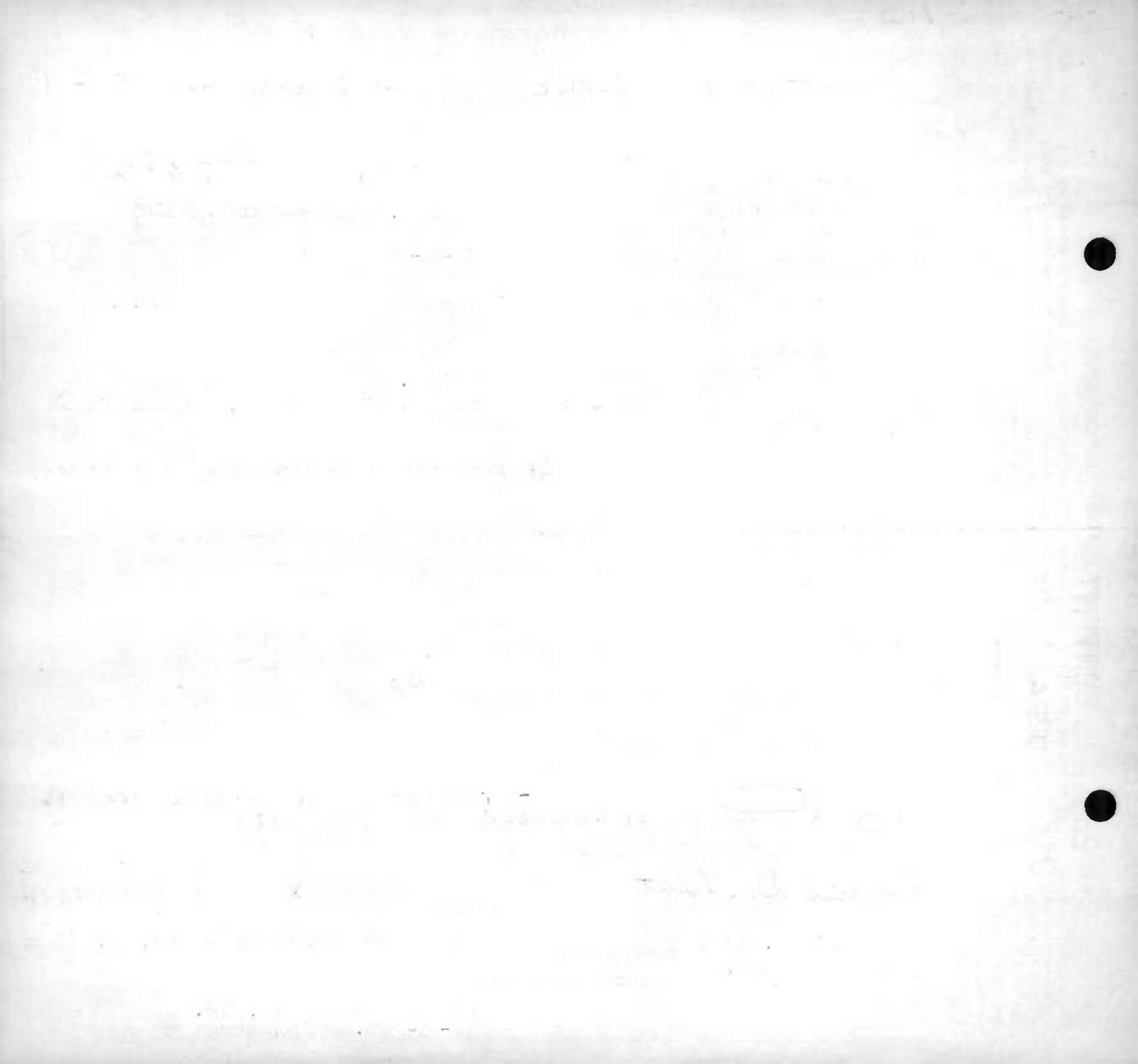
CERTIFICATE OF DEATH

Registered No.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

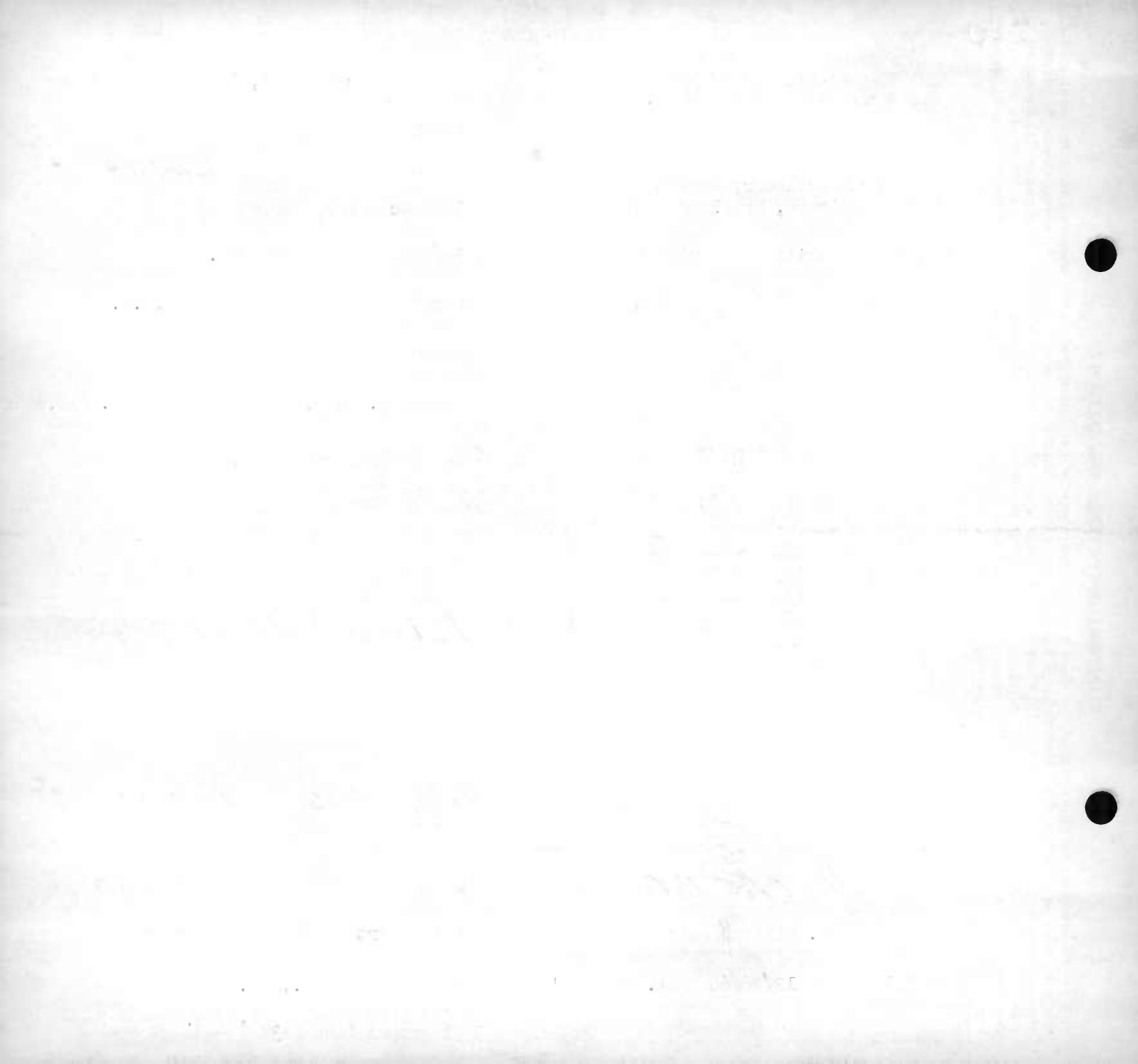
| | | | |
|--|---------------------------|--|---|
| BIRTH NO. 66 12864 | | M.E. CASE NO. | |
| 1. NAME OF DECEASED (Type or Print) MATTHEW CLARK | | 2. DATE AND HOUR OF DEATH 21 DECEMBER 1966 5 00 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224 | | C. CITY OR TOWN (If outside city limits, write RURAL or give township) Baltimore, 6-02 | |
| | | D. STREET ADDRESS (If rural, give location) 2429 E. Jefferson Street #21205 | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 10-13-89 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Janitor | | 10B. KIND OF BUSINESS OR INDUSTRY Patterson High School | 9. AGE (In years last birthday) 77 |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME George Clark | | 14. MOTHER'S MAIDEN NAME Jane Goodwin | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 214-40-4239 | 17. INFORMANT Minnie F. Clark ADDRESS 4940 Eastern Avenue |
| 18. 430.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) GENERALIZED ARTERIOSCLEROSIS SEV. YEARS. | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | |
| 19. DATE OF OPERATION 0 | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | |
| 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 5 AUGUST 1966 to 21 DECEMBER 1966 , that (I) (we) last saw the deceased alive on 21 DECEMBER 1966 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE Daniel D. Foote M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | |
| 23B. DATE SIGNED 21 DECEMBER 1966 | | 23C. PHYSICIAN'S NAME (Type) Daniel D. Foote M.D. | |
| 23D. ADDRESS 4940 Eastern Avenue | | 23E. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. ADDRESS 2601-03-05 E. Madison Street #5 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 12/24/66 | 24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery | 24D. LOCATION (City, town, or county) (State) Maryland |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | 25B. NAME OF REGISTRAR Robert E. ... | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 12865</u> | |
|--|-------------------------|---|------------------------------------|---|---|
| BIRTH NO. <u>66 12865</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>AMELIA MILLER</u> | | 2. DATE AND HOUR OF DEATH <u>December 23, 1966</u> <u>5</u> am M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>00 3221 McElderry Street Baltimore, Maryland 21205</u> | | A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>26-10</u> D. STREET ADDRESS (If rural, give location) <u>3221 McElderry Street #5</u> | | | |
| 5. SEX <u>female</u> | 6. RACE <u>white</u> | 7. MARRIED, NEVER MARRIED <u>WIDOWED, DIVORCED (specify)</u> <u>widowed</u> | 8. DATE OF BIRTH <u>2/16/87</u> | 9. AGE (In years last birthday) <u>19 yrs.</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Germany</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Unknown</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <u>Margaret H. Acor, 1512 Loch Wood Rd. #18, dght.</u> | |
| 18. <u>423.1</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>arteriosclerotic cardiac</u> <u>vascular disease</u> <u>heart failure</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH <u>2 yr</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | <u>Parkinson's Disease</u> | | <u>3 yr</u> | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>no</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> 19 <u>61</u> to <u>Dec 23</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Nov</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Dr. Milton B. Kress</u> M.D. | | | | 23B. DATE SIGNED <u>Dec 23, 1966</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Dr. Milton B. Kress</u> | | 23D. ADDRESS <u>Medical Arts Building</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12/26/66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>St. Matthew's Cemetery</u> | |
| 24D. LOCATION <u>Balto., Md.</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 27 1966</u> | | 25B. NAME OF REGISTRAR <u>Robert E. ...</u> | | 25C. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u> | |
| 25D. ADDRESS <u>8331 Brehms Lane #13</u> | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. _____ | |
|---|-------------------------|--|------------------------------------|--|---|
| BIRTH NO. 66 12866 | | CERTIFICATE OF DEATH | | 66 12866 | |
| M.E. CASE NO. _____ | | 1. NAME OF DECEASED (Type or Print) Oscar Christenson | | 2. DATE AND HOUR OF DEATH 12/15/66 M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) DOA Maryland General Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY _____ C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 517 Cathedral St. | | | |
| 5. SEX M | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH 6/12/84 | 9. AGE (In years last birthday) 84 | If Under 1 Yr. Months: _____ Days: _____ If Under 24 Hrs. Hours: _____ Min: _____ |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown | | 10B. KIND OF BUSINESS OR INDUSTRY Unknown | | 11. BIRTHPLACE (State or foreign country) North Dakota | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI | | 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT ADDRESS Veterans Administration Records | |
| 18. 720.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Chronic Sclerosis of Heart ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH 1 mo | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. NO | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec 1 19 66 to Dec 15 19 66 , that (I) (we) last saw the deceased alive on Dec 12 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE F. Fred Ružicka | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED Dec 21-66 | |
| 23C. PHYSICIAN'S NAME (Type) F. Fred Ružicka | | 23D. ADDRESS 800 N. Patterson Park Ave. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12/23/66 | | 24C. NAME of CEMETERY or CREMATORY Baltimore National | |
| 24D. LOCATION Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | | |
| 25B. NAME OF REGISTRAR Robert E. J. [illegible] | | 25C. FUNERAL DIRECTOR ADDRESS Robert E. J. [illegible] 6009 Harford Road | | | |

100 N. Patterson Park Ave.

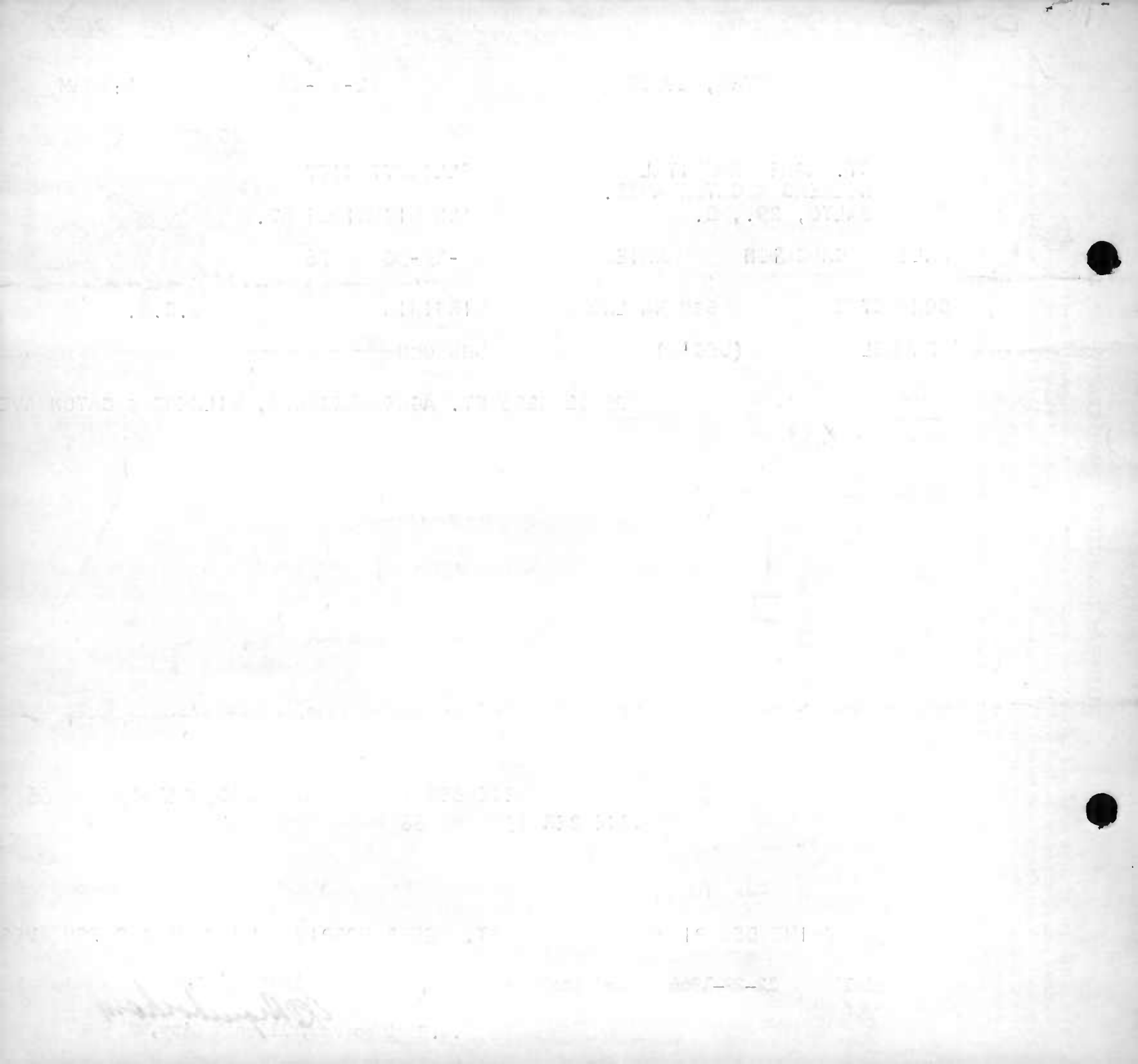
P. Fred [illegible]

Bureau of Botanical Research
100 N. Patterson Park Ave.
Baltimore, Maryland

FUNERAL DIRECTOR: IMPORTANT

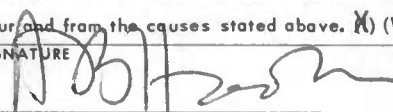
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

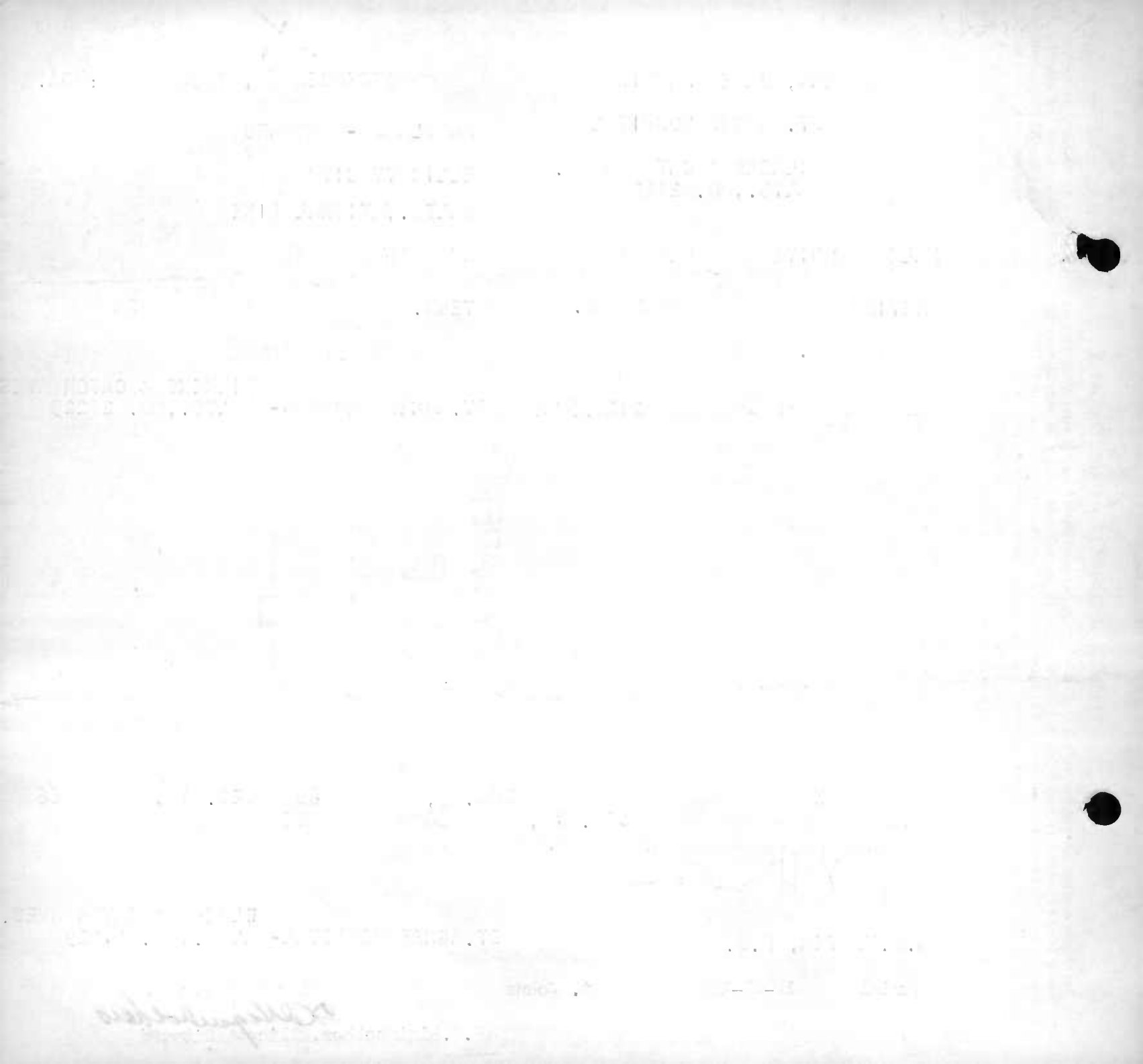
| | | | |
|--|--|--|--|
| <p>6-30 66 12867</p> <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p> | | <p>Registered No. 66 12867</p> | |
| <p>BIRTH NO. 66 12867</p> <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) BYRD, LOUIS</p> | | <p>2. DATE AND HOUR OF DEATH 12-19-66 2:10AM M.</p> | |
| <p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL WILKENS & CATON AVES. BALTO, 29., MD.</p> | | <p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE MD B. COUNTY HOWARD</p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) ELLICOTT CITY</p> <p>D. STREET ADDRESS (If rural, give location) 122 HIGHRIDGE RD.</p> | |
| <p>5. SEX MALE</p> | <p>6. RACE CAUCASION</p> | <p>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED</p> | <p>8. DATE OF BIRTH 08-23-90</p> |
| <p>9. AGE (In years last birthday) 76</p> | | <p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONDUCTOR</p> | <p>11. BIRTHPLACE (State or foreign country) VIRGINIA</p> |
| <p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONDUCTOR</p> | | <p>10B. KIND OF BUSINESS OR INDUSTRY B&O RAILROAD</p> | <p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p> |
| <p>13. FATHER'S NAME SAMUEL (DEC'D)</p> | | <p>14. MOTHER'S MAIDEN NAME UNKNOWN</p> | |
| <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, unknown) (If yes, give war or dates of service) NO</p> | | <p>16. SOCIAL SECURITY NO. 705 12 0226</p> | <p>17. INFORMANT ADDRESS ST. AGNES RECORDS, WILKENS & CATON AVE</p> |
| <p>18. CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>INTERVAL BETWEEN ONSET AND DEATH</p> <p>(A) Intestinal Obstruction</p> <p>(B) metastasis</p> <p>(C) Carcinoma of Stomach</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. pulmonary edema.</p> | | | |
| <p>19A. DATE OF OPERATION 12/16/66</p> | <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED intestinal obstruction</p> | <p>20A. AUTOPSY? (Yes or No) NO</p> | <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p> |
| <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p> | <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> | <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p> | |
| <p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p> | <p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p> | <p>21F. HOW DID INJURY OCCUR?</p> | |
| <p>22. I certify that (I) (this hospital) attended the deceased from DECEMBER 10 19 66 to DECEMBER 19 19 66, that (I) (we) last saw the deceased alive on DECEMBER 19 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p> | | | |
| <p>23A. SIGNATURE Jaime V. Del Pilar</p> | | <p>M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/></p> | <p>23B. DATE SIGNED 12/19/66</p> |
| <p>23C. PHYSICIAN'S NAME (Type) JA JAIME DEL PILAR</p> | | <p>23D. ADDRESS ST. AGNES HOSPITAL WILKENS & CATON AVES</p> | |
| <p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p> | <p>24B. DATE 12-22-1966</p> | <p>24C. NAME OF CEMETERY or CREMATORY Good Shepherd</p> | <p>24D. LOCATION (City, town, or county) (State) Ellicott City, Md.</p> |
| <p>25A. DATE REC'D BY HEALTH DEPT. DEC 27 1966</p> | <p>25B. NAME OF REGISTRAR Robert E. Taylor</p> | <p>25C. FUNERAL DIRECTOR F.C. Higginbotham, Ellicott City, Md</p> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|-------------------------|--|---|---|---|---|--|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 66 12868 | | | | |
| BIRTH NO. 66 12868 | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED (Type or Print) ROGERS, JAMES RANKIN | | | | | 2. DATE AND HOUR OF DEATH DECEMBER 18, 1966 8:40A. M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL (If not in hospital or institution, give street address or location) WILKENS & CATON AVES. BALTO., MD. 21229 | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY HOWARD | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) ELLICOTT CITY | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) BALTO. NATIONAL PIKE | | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED MARRIED | 8. DATE OF BIRTH MAY 1900 | 9. AGE (In years last birthday) 66 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | | 10B. KIND OF BUSINESS OR INDUSTRY Motel Prop. | | 11. BIRTHPLACE (State or foreign country) TENN. | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME JAMES W. ROGERS | | | | | 14. MOTHER'S MAIDEN NAME MARY ALICE ROGERS | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. 212033543 | | 17. INFORMANT WILKENS & CATON AVES. BALTO., MD. 21229 | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Uremia | | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| 19A. DATE OF OPERATION 2 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from DEC. 9, 1966 to DEC. 18, 1966 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on DEC. 18, 1966 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) XXXX view the body after death. | | | | | | | | | |
| 23A. SIGNATURE  | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | | |
| 23C. PHYSICIAN'S NAME (Type) A.B. HOOTEN, M.D. | | | | | 23D. ADDRESS WILKENS & CATON AVES. ST. AGNES HOSPITAL-BALTO., MD. 21229 | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-21-1966 | | 24C. NAME OF CEMETERY or CREMATORY St. Johns | | 24D. LOCATION (City, town, or county) (State) Ellicott City, Md | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | 25B. NAME OF REGISTRAR A. E. E. Taylor | | 25C. FUNERAL DIRECTOR F.C. Higinbotham, Ellicott City, Md | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | |
|--|--|--------------|--|--|--|--|--|---|-------------------------------------|---|--|
| 66 12869 | | | | | Registered No. 66 12869 | | | | | | |
| BIRTH NO. | | | | | M.E. CASE NO. | | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | | 2. DATE AND HOUR OF DEATH | | | | | | |
| Edward Reeves | | | | | Dec 23, 1966 7 ²⁰ A.M. | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | | |
| Full Name of Institution (If not in hospital or institution, give street address or location) 4949 4th Charles Avenue | | | | | A. STATE B. COUNTY Md Baltimore | | | | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) Md 13-08 | | | | | D. STREET ADDRESS (If rural, give location) 1325 Union Ave | | | | | | |
| 5. SEX M | | 6. RACE W | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married | | 8. DATE OF BIRTH 12/31/1900 | | 9. AGE (In years last birthday) 65 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired River Arundel Corp | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Md. USA | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME Robert C. Reeves | | | | | 14. MOTHER'S MAIDEN NAME Margaret Callahan | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | | | | 16. SOCIAL SECURITY NO. 219-01-5166 | | 17. INFORMANT ADDRESS Josephine Reeves-1325 Union Ave | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH (A) DUE TO Coronary Artery Sclerotic (B) DUE TO Bronchitis + (C) DUE TO Myocardial Infarction | | | | | INTERVAL BETWEEN ONSET AND DEATH Several | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Bronchitis Fracture of rib = rib fracture | | | | | | | | | | | |
| 19A. DATE OF OPERATION 12/14/66 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) Yes (Rt) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Nov 26 1966 to Dec 23 1966, that (I) (we) last saw the deceased alive on Dec 22 1966 at 10:30 AM and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE James E.T. Hopkins | | | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | | |
| 23C. PHYSICIAN'S NAME (Type) JAMES E.T. HOPKINS | | | | | | | 23D. ADDRESS M.D. 2054 Sawback St | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 24B. DATE 12/27/66 | | 24C. NAME of CEMETERY or CREMATORY Woodlawn | | | 24D. LOCATION (City, town, or county) (State) Woodlawn, Md | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | | 25B. NAME OF REGISTRAR A. E. E. Tolson | | | 25C. FUNERAL DIRECTOR Austin C. Donovan | | | ADDRESS 3818 Roland Ave | | |

100

1. The first thing I noticed
when I stepped out of the plane
was the cold air. It was a
shock to the system. I had
heard that the weather was
bad, but I didn't realize it
would be so cold.

2. The second thing I noticed
was the noise. It was a
constant hum that seemed to
come from everywhere. I
wasn't used to it, and it
was a bit annoying. I
tried to ignore it, but it
was hard to do.

3. The third thing I noticed
was the view. It was
amazing. I had never seen
so many mountains before.
They were so high and so
beautiful. I was in luck.

4. The fourth thing I noticed
was the people. They were
friendly and helpful. I
wasn't used to that either.
I had heard that the people
were rude, but they were
not.

5. The fifth thing I noticed
was the food. It was
delicious. I had never
eaten anything like it before.
It was a real treat. I was
in luck.

6. The sixth thing I noticed
was the culture. It was
different. I had never
experienced anything like it
before. It was a real
challenge, but it was also
a real reward.

7. The seventh thing I noticed
was the language. It was
hard to hear. I had never
heard anything like it before.
I was in luck.

8. The eighth thing I noticed
was the weather. It was
perfect. I had never
experienced anything like it
before. It was a real
reward.

RELEASED BY CMO

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-----------|--|---|--|---|
| BIRTH NO. 66 12870 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12870 | |
| M.E. CASE NO. | | | 1. NAME OF DECEASED (Type or Print) Harry R. Burns | | |
| 1. NAME OF DECEASED (Type or Print) | | | 2. DATE AND HOUR OF DEATH Dec. 20, 1966 6:05 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital | | | A. STATE Maryland | | |
| 37 | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 9-01 | | |
| | | | D. STREET ADDRESS (If rural, give location) 529 Rose Hill terrace | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 8-31-99 | 9. AGE (In years last birthday) 67 | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman | | 10B. KIND OF BUSINESS OR INDUSTRY Proctor & Bamble | | 11. BIRTHPLACE (State or foreign country) New York | |
| 13. FATHER'S NAME Henry Burns | | 14. MOTHER'S MAIDEN NAME TechLa Duerr | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 218-07-8935 | | 17. INFORMANT Marguerite C. Burns (Wife) Same | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | CAUSE OF DEATH | | |
| ANTECEDENT CAUSES | | | Respiratory Failure | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | Bronchopneumonia | | |
| II | | | Acute Myocardial Infarction | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | Pulmonary emphysema | | |
| 19A. DATE OF OPERATION 2 NONE | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hospital room | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) Dec. 16, 1966 6 AM | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec. 8, 1966 to Dec. 20, 1966 and that (I) (we) last saw the deceased alive on Dec. 20, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | 20A. AUTOPSY? (Yes or No) yes | | |
| 23A. SIGNATURE Richard D. Shuger M.D. | | | 20B. IF YES, WERE FINDINGS CONSISTENT IN CERTIFYING CAUSES OF DEATH? yes | | |
| 23C. PHYSICIAN'S NAME (Type) RICHARD D. SHUGER M.D. | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Mercy Hosp. Rm 1008-2 | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 21F. HOW DID INJURY OCCUR? Attempted to leave bed, fell on floor while in somnambulant state | | |
| 24B. DATE 12/24/1966 | | | 23B. DATE SIGNED 12/20/66 | | |
| 24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | | 25B. NAME OF REGISTRAR | | |
| 25C. FUNERAL DIRECTOR ADDRESS Eugenia K. Seitz 5209 York Rd. Seitz Funeral Home Balto. Md. 21212 | | | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. 66 12871 | | CERTIFICATE OF DEATH | | Registered No. 66 12871 | |
|---|--|--|--|---|--|---|---|---|--|
| 1. NAME OF DECEASED (Type or Print) <u>William H. Brown</u> | | | | 2. DATE AND HOUR OF DEATH <u>12/19/66</u> <u>2:45</u> A.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>MERCY HOSPITAL</u> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTO Anne Arundel</u> | | | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>GLEN BURNIE</u> <u>52-00</u> | | | | | |
| | | | | D. STREET ADDRESS (If rural, give location) <u>419 3RD AVE. S.W.</u> | | | | | |
| 5. SEX <u>M</u> | | 6. RACE <u>W</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u> | | 8. DATE OF BIRTH <u>9/14/06</u> | | 9. AGE (in years last birthday) <u>60</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRoubleman</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>BALTO. GAS SELECT.</u> | | 11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | |
| 13. FATHER'S NAME <u>EDWIN P. BROWN</u> | | | | 14. MOTHER'S MAIDEN NAME <u>LUCY LOUISE WEBB</u> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>yes</u> | | If yes, give war or dates of service <u>NAVY 1924</u> | | 16. SOCIAL SECURITY NO. <u>212-055658</u> | | 17. INFORMANT <u>Catherine M. Brown (wife)</u> ADDRESS | | | |
| 18. <u>157X</u> CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) <u>ACUTE MYOCARDIAL INFARCTION</u> <u>RECENT</u> | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) <u>WIDESPREAD CARCINOMATOSIS</u> | | | | | |
| | | | | (C) <u>PROBABLE CA OF PANCREAS</u> | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION <u>2</u> <u>NONE</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>yes.</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u> | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12/12</u> <u>1966</u> to <u>12/19</u> <u>1966</u> , that (I) (we) last saw the deceased alive on <u>12/19</u> <u>1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>B. Ominsky</u> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>12/19/66</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>BARRY Ominsky</u> | | | | 23D. ADDRESS <u>MERCY HOSPITAL</u> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12-22-66</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial Pk.</u> | | 24D. LOCATION (City, town, or county) (State) <u>Glen Burnie Md.</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 27 1966</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Talbot</u> | | 25C. FUNERAL DIRECTOR <u>Singleton Funeral Home</u> | | ADDRESS <u>Glen Burnie Md.</u> | | | |

for my own personal collection on account of

2

Printed and Published by the
Singapore Press, No. 11, Cross Street, Singapore.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|--|--|--|--|
| BIRTH NO. 66 12872 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12872 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | 1. NAME OF DECEASED | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | |
| SCHNEPF, Mrs. Joseph, D. | | 12-21-66 1:00 A.M. | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE | | B. COUNTY | |
| Church Home & Hospital | | Maryland | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| 100 N. Broadway | | Baltimore | | D. STREET ADDRESS (If rural, give location) | |
| Baltimore, Md. | | 2904 Hudson St. #21224 | | 5. SEX | |
| MALE | | 6. RACE | | 7. MARRIED, NEVER MARRIED | |
| WHITE | | WIDOWED, DIVORCED (specify) | | MARRIED | |
| 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | |
| 7-24-98 | | 68 | | Retired | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | |
| BALTIMORE, Maryland | | American | | JOHN SCHNEPF. | |
| 14. MOTHER'S MAIDEN NAME (DILLHOFER) | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| PRISCILLA DILLHOFER | | NO | | 214-01-4325 | |
| 17. INFORMANT | | 18. CAUSE OF DEATH | | 19. ADDRESS | |
| EMMA SCHNEPF (wife) | | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | 2904 Hudson St. | |
| | | (A) PULMONARY EMBOLISM | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | DUE TO ARTERIOSCLEROTIC HEART DISEASE | | weeks | |
| | | (B) HYPERTENSION | | years | |
| | | DUE TO PERIPHERAL VASCULAR DISEASE | | days | |
| | | (C) URINARY TRACT INFECTION | | | |
| | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| D | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-10 1966 to 12-21 1966, that (I) (we) lost saw the deceased alive on 12-21 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Emma Schaefer M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 12-21-66 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Norona Schaefer M.D. | | Church Home & Hospital Baltimore, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| BURIAL | | 12-24-66 | | GARDENS OF FAITH | |
| 24D. LOCATION (City, town, or county) | | 24E. DATE REC'D BY HEALTH DEPT. | | 24F. NAME OF REGISTRAR | |
| KENWOOD AVE & TRUMPS MILL RD, BALTO, CO., MD. | | DEC 27 1966 | | Charles J. Gales | |
| 24G. FUNERAL DIRECTOR | | 24H. ADDRESS | | 24I. DATE | |
| Charles J. Gales | | 901 S. CONKLING ST., BALTO., 21224, MD. | | | |

12-21-20

Completed

Part 1 more

904 Hudson St

12-21-20

Completed

Completed (up)

Part 2 more

Completed

15-21-20

Completed

Completed

Completed

Completed

Completed

Completed

Completed

Completed

Completed

Completed

Completed

Completed

Completed

Completed

Completed

Completed

Completed

Completed

Completed

Completed

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------|--|--|---|---|
| BIRTH NO. 66 12873 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 12873 | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) HERMAN L. MOMBERGER | | | DECEMBER 24, 1966 3 A. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SOUTH BALTIMORE GENERAL HOSPITAL | | | A. STATE MARYLAND | | |
| | | | B. COUNTY | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21230 | | |
| | | | D. STREET ADDRESS (If rural, give location) 1729 PATAPSCO STREET | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| MALE | WHITE | SINGLE | 4-8-1892 | 74 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| RETIRED | | | Jeweler | | MARYLAND |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| John Momberger | | | WILHELMINA KROENING | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS |
| Yes # 1 | | | | | Family Same |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | CAUSE OF DEATH | | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | (A) Caecumonia of the lung | | |
| ANTECEDENT CAUSES | | | (B) DUE TO | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (C) DUE TO | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (netify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that X (this hospital) attended the deceased from DECEMBER 18, 1966 to DECEMBER 24, 1966 , that X (we) last saw the deceased alive on DECEMBER 24, 1966 and that in X (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE William J. Bruther M.D. | | | | 23B. DATE SIGNED 12-24-66 | |
| 23C. PHYSICIAN'S NAME (Type) William Bruther M.D. | | | | 23D. ADDRESS SOUTH BALTIMORE GENERAL HOSPITAL 1213 Light Street Balto. Md. 21230 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 12 27 1966 | | Cedar Hill | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| DEC 27 1966 | | J. E. Taylor | | Mc Cully 130 E. Fort Ave | |

John member
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William Butler

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|-------------------------|--|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. <u>66 12874</u> | |
| BIRTH NO. <u>66 12874</u> | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH <u>Dec. 20, 1966</u> <u>12:30 P.</u> M. | |
| 1. NAME OF DECEASED (Type or Print) <u>Lillian E. Brickman</u> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>5409 Catalpha Rd.</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> <u>21214</u> <u>27-06</u> | |
| | | D. STREET ADDRESS (If rural, give location) <u>5409 Catalpha Rd.</u> | |
| 5. SEX <u>Female</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED <u>WIDOWED, DIVORCED (specify)</u> <u>Married</u> | 8. DATE OF BIRTH <u>5/18/1922</u> |
| | | 9. AGE (In years last birthday) <u>43</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Records Dept.</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Church Home Hosp.</u> | 11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u> |
| | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>William Hands</u> | | 14. MOTHER'S MAIDEN NAME <u>Blahche Headley</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>235-24-5038</u> | |
| | | 17. INFORMANT <u>Mr. Eugene Brickman- Same</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma of Breast</u> <u>generalized metastasis</u> <u>lymph gland, bone</u> <u>+ Brain</u> | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Nov 15</u> 19 <u>66</u> to <u>Dec 20</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12/19</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <u>Dr. O. W. Minter</u> | | 23B. DATE SIGNED <u>12/22/66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>DONALD W. MINTER</u> | | 23D. ADDRESS <u>3009 EVERGREEN AVE BALTO MD</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12/23/66</u> | |
| 24C. NAME OF CEMETERY or CREMATORY <u>Arlington National Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 27 1966</u> | | 25B. NAME OF REGISTRAR <u>John E. ...</u> | |
| 25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. 5305 Harford Rd. #14</u> | | ADDRESS | |

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2. The second part of the document

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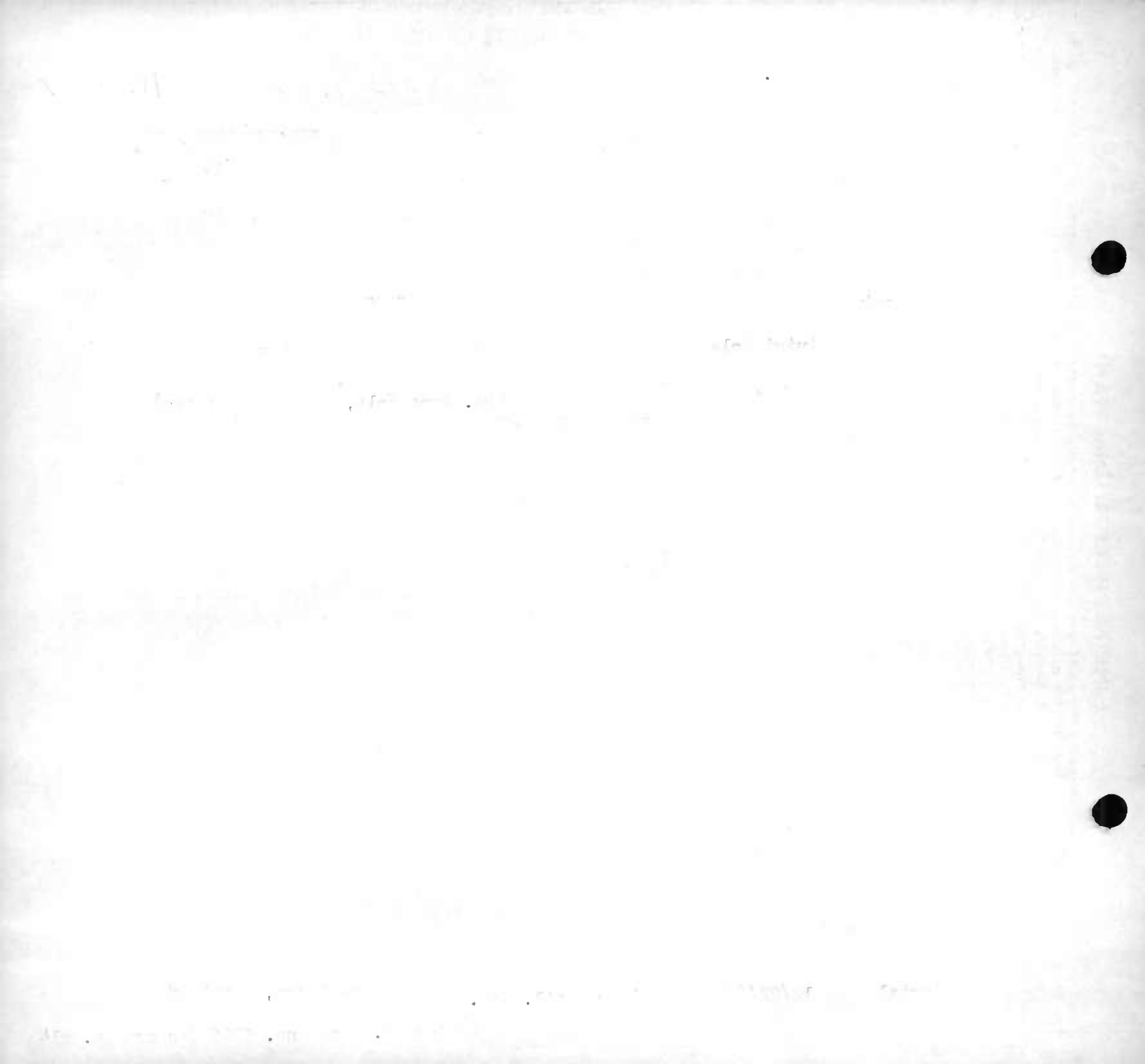
4. The fourth part of the document

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

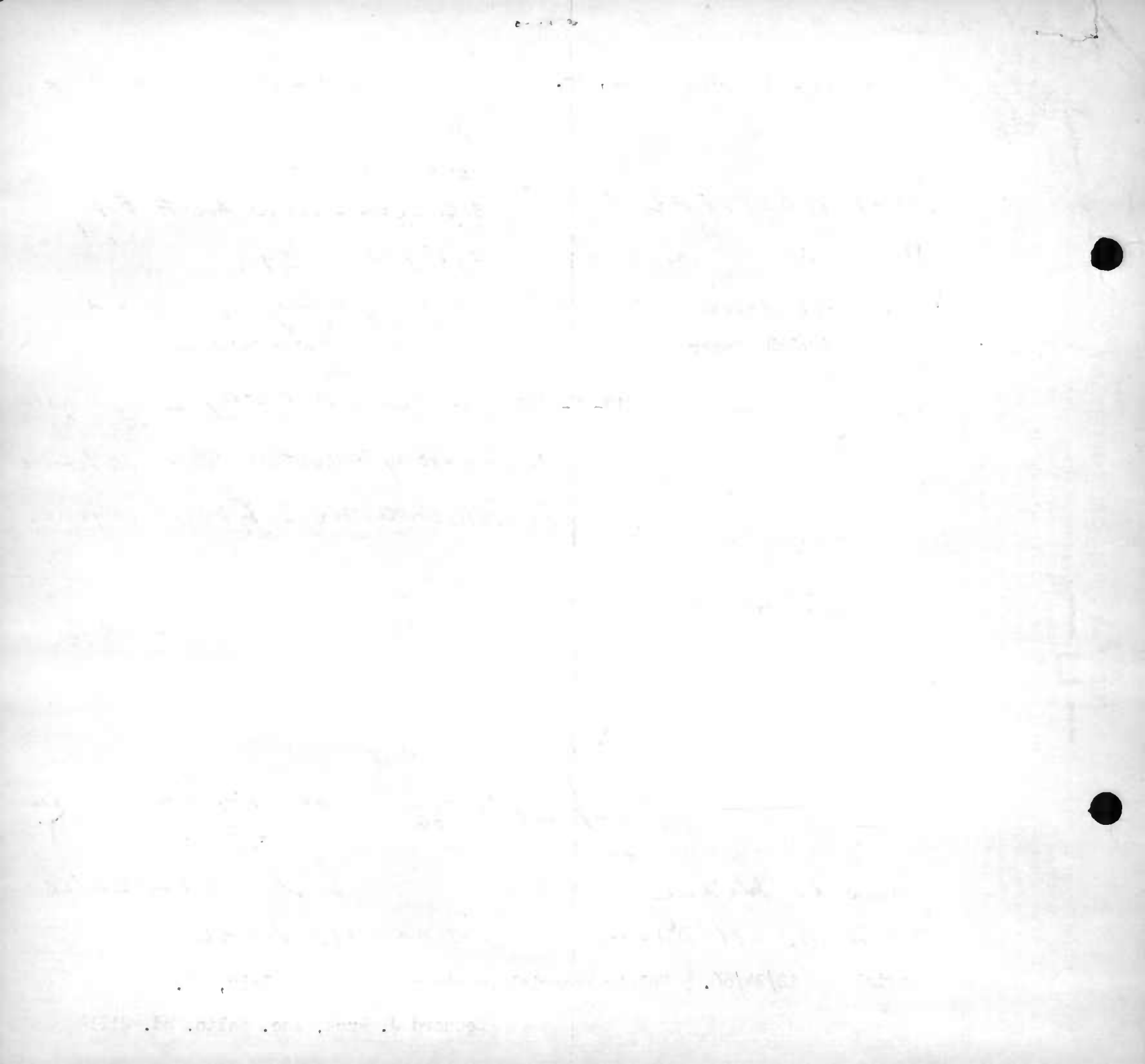
| Baltimore City Health Department | | | | Registered No. 66 12875 | |
|--|--|--|--|--|--|
| 66 12875 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Arthur G. Vola</i> | |
| 2. DATE AND HOUR OF DEATH <i>12/21/66 11:45 P.M.</i> | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Sinai Hospital of Baltimore, Inc.</i> | | (If not in hospital or institution, give street address or location) | | | |
| 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore #14 27-44</i> | | | |
| D. STREET ADDRESS (If rural, give location) <i>5900 Edna Ave.</i> | | 5. SEX <i>M</i> 6. RACE <i>W</i> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i> | | | |
| 8. DATE OF BIRTH <i>10/22/91</i> | | 9. AGE (In years last birthday) <i>75</i> | | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cook</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>France</i> | |
| 12. CITIZEN OF WHAT COUNTRY <i>USA</i> | | 13. FATHER'S NAME <i>Luigi Vola</i> | | 14. MOTHER'S MAIDEN NAME <i>Unknown</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes WW1</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Mrs. Anna Vola,</i> | |
| ADDRESS <i>(Same)</i> | | 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>420.0 Atherosclerotic heart disease</i> | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH <i>15 years</i> | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Emphysema</i> | | (B) DUE TO | | | |
| (C) DUE TO | | | | | |
| 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>Yes</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Sept 1961</i> to <i>Dec 1966</i> , that (I) (we) lost saw the deceased alive on <i>December 21, 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Robert I. Levy</i> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>12/21/66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Robert I. Levy</i> | | M.D. 23D. ADDRESS <i>114 Medical Ctr</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12/22/66</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Baltimore Natl. Cem.</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 21 1966</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Johnson</i> | | 25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc.</i> | |
| ADDRESS <i>5305 Harford Rd. #14</i> | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|---------------------|---|------------------------------------|--|--|--|--|
| BIRTH NO. 260 | | 66 12876 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12876 | |
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) WILLIAM MOSER, Sr. | | | |
| 2. DATE AND HOUR OF DEATH 12/22/66 6.30 A.M. | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL (If not in hospital or institution, give street address or location) | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3121 CLEARVIEW Ave # 34 | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 6/13/07 | 9. AGE (In years last birthday) 59 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired steel worker | | 10B. KIND OF BUSINESS OR INDUSTRY STEEL Co. | | 11. BIRTHPLACE (State or foreign country) New Jersey | | 12. CITIZEN OF WHAT COUNTRY? U.S.A | |
| 13. FATHER'S NAME Adolph Moser | | | | 14. MOTHER'S MAIDEN NAME Helen Teichman | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 213-07-2650 | | 17. INFORMANT Wife: Dorothy L | | ADDRESS SAME | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) Respiratory obstruction: ANOXIA DUE TO (B) Chronic obstructive Lung Disease DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 10 hours 10 years 2 weeks | |
| | | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. BRONCHITIS | | | |
| | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/21 19 66 to 12/22 19 66 , that (I) (we) last saw the deceased alive on 12/21 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Eduardo Hidalgo M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED 12/22/66 | | | |
| 23C. PHYSICIAN'S NAME (Type) EDUARDO HIDALGO M.O. | | | | 23D. ADDRESS SINAI HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/24/66. | | 24C. NAME OF CEMETERY or CREMATORY Belair Memorial Cemetery | | 24D. LOCATION (City, town, or county) (State) Belair, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | 25B. NAME OF REGISTRAR Robert E. ... | | 25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214 | | ADDRESS | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

66 12877

Registered No.

66 12877

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

AUGUSTINA (AGNES)

D.

~~EMERICK~~ CURREN

2. DATE AND HOUR PRONOUNCED DEAD

December 21, 1966

10:40 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

4605 Hazelwood Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4605 Hazelwood Avenue

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

August 13, 1902

9. AGE (In years
last birthday)

64

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Frank Cimino

14. MOTHER'S MAIDEN NAME

Josephine Cimino

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Frank J. Current 9406 Fullerdale Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
12/22/6623A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/26/66.

23C. NAME of CEMETERY or CREMATORY

Holy Redeemer Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

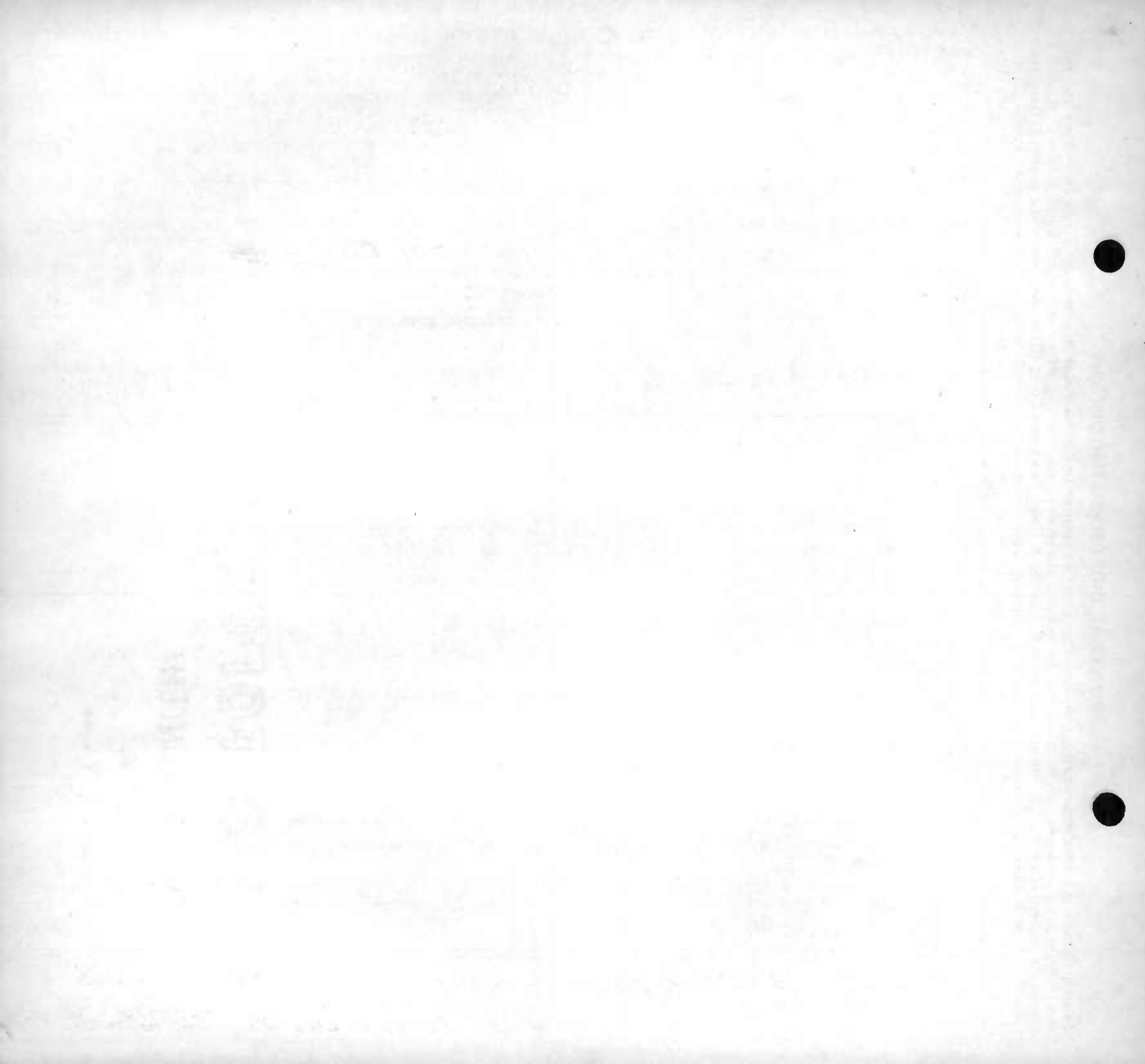
Leonard J. Ruck, Inc. Balto. Md. 21214

WALLEY FORTS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

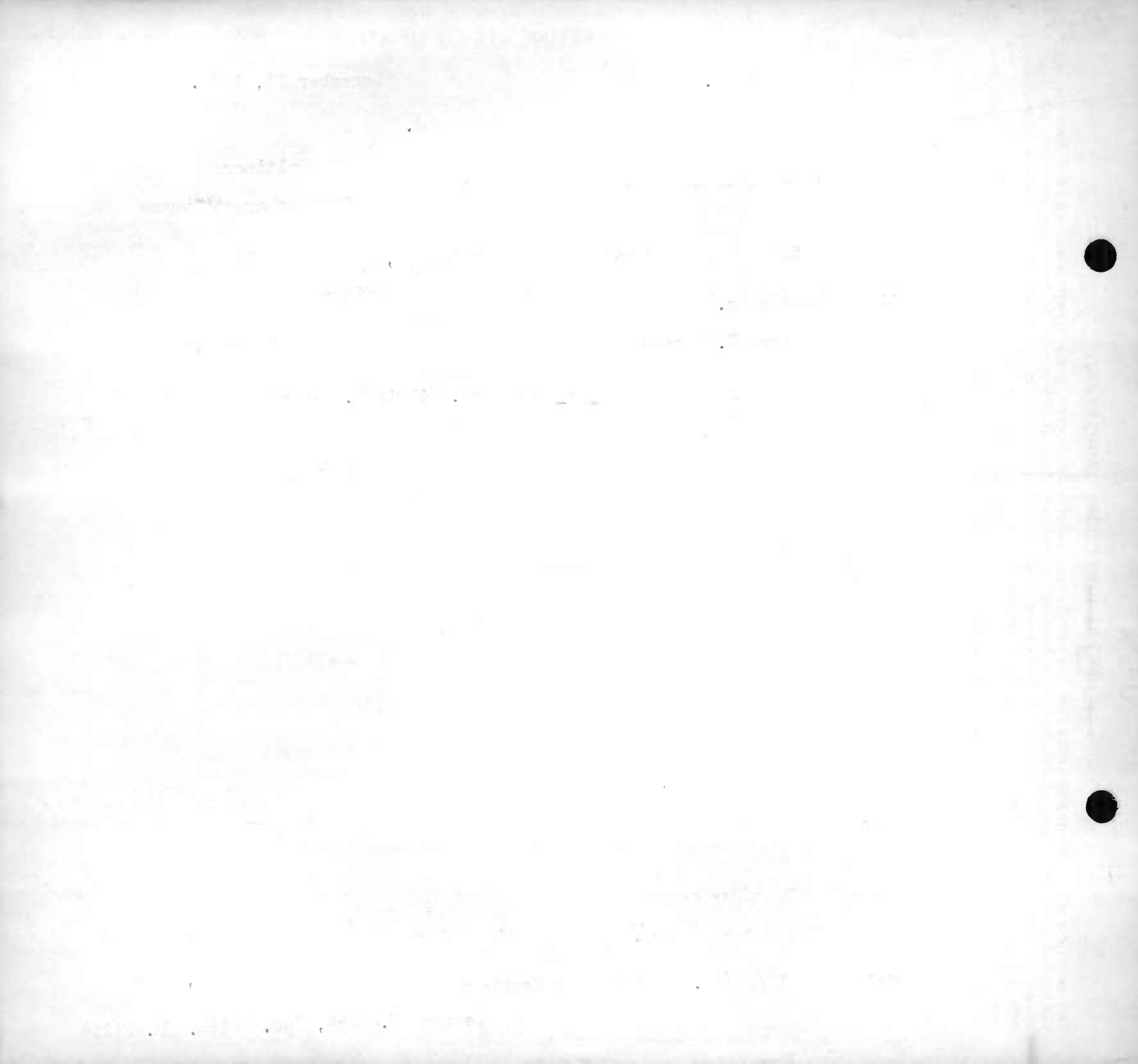
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12878 | |
|--|---------------|--|---------------------------|--|---|
| BIRTH NO. 66 12878 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) GEBELEIN ROSA, M. | | 2. DATE AND HOUR OF DEATH 21. DECEMBER 66 442 PM. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL 44 BALTIMORE | | A. STATE MARYLAND B. COUNTY | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21218 | | | |
| | | D. STREET ADDRESS (If rural, give location) 414 E. 31. ST. STREET | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED | 8. DATE OF BIRTH 12-31-02 | 9. AGE (In years lost birthday) 63 | 10. Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CASHIER | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) GERMANY | |
| 12. CITIZEN OF WHAT COUNTRY? AMERICAN | | 13. FATHER'S NAME ERNEST MUELLER | | 14. MOTHER'S MAIDEN NAME MARGARET | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 219-30-1224 | | 17. INFORMANT ADDRESS HOWARD A. GEBELEIN, ANNAPOLIS, MD. | |
| 18. 331X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH (A) CEREBRAL HEMORRHAGE (B) CEREBRAL ANEURYSM (C) ON ANT COMMUNICATING ARTERIE | | INTERVAL BETWEEN ONSET AND DEATH 1 month | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | II HYPERTENSION | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nobly medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 11-21 1966 to 12-21 1966, that (I) (we) lost saw the deceased alive on 12-21 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Fridtjofur Bjornsson M.D. | | 23B. DATE SIGNED 12-21-1966 | | | |
| 23C. PHYSICIAN'S NAME (Type) FRIDTJOFUR BJORNSSON M.D. | | 23D. ADDRESS UNION MEMORIAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12/24/66 | | 24C. NAME OF CEMETERY OR CREMATORY PARKWOOD CEMETERY | |
| | | | | 24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS LEONARD J. FUCH WK 5305 HANCOCK RD #14 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12879 | |
|--|------------------|--|-------------------------------------|--|--|
| BIRTH NO. 66 12879 | | CERTIFICATE OF DEATH | | Registered No. 66 12879 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) EARL D. DENMAN | | 2. DATE AND HOUR OF DEATH December 21, 1966. 4:45 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 00 3005 Oakcrest Avenue | | A. STATE Md. B. COUNTY | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 27-05 | | | |
| D. STREET ADDRESS (If rural, give location) 3005 Oakcrest Avenue | | | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH August 21, 1896 | 9. AGE (in years last birthday) 70 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired (Martin Co.) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Indiana | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Harry C. Denman | | 14. MOTHER'S MAIDEN NAME Corell | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) YES W W I | | 16. SOCIAL SECURITY NO. 218-01-1174 | | 17. INFORMANT ADDRESS Mrs. Silvia M. Denman (Same) | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO Arteriosclerotic Cardiovascular disease | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from November 9, 1965 to Dec. 21, 1966 that (I) (we) last saw the deceased alive on November 9, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE James E. White | | M.D. Attending <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED Dec. 21/66 | |
| 23C. PHYSICIAN'S NAME (Type) James E. White | | M.D. 23D. ADDRESS 5214 HARFORD ROAD 21214 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/24/66. | | 24C. NAME OF CEMETERY or CREMATORY Green Lawn Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Columbus, Ohio | | 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | 25B. NAME OF REGISTRAR Leonard J. Ruck, Inc. Balto. Md. 21214 | |
| 25C. FUNERAL DIRECTOR ADDRESS | | 25D. NAME OF REGISTRAR | | 25E. FUNERAL DIRECTOR ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 12880 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12880 | |
|--|-------------------------|--|---|---|---|--|---|
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Eleanor A. Kapp | | | | 2. DATE AND HOUR OF DEATH 12/22/66 5 a.m. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND 2739 Cylburn Ave. 21215 <small>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</small> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 2739 Cylburn Ave. 21215 | | | |
| 5. SEX F. | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 7/27/1906 | 9. AGE (In years lost birthday) 60 | If Under 1 Yr. Months | If Under 24 Hrs. Days | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Chicago, Ill. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Hans Hansen | | | 14. MOTHER'S MAIDEN NAME Augusta Norrgard | | 17. INFORMANT ADDRESS Mr. Wm. M. Kapp-2739 Cylburn Ave. 21215 | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. No | | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <small>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</small> ANTECEDENT CAUSES <small>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</small> | | | | CAUSE OF DEATH (A) DUE TO Rheumatic Heart Disease (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 20 yrs | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | Intely arthritis | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1965 to 12/23/66 that (I) (we) last saw the deceased alive on 12/21/66 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Dr. Joseph Shear M.D. | | | | 23B. DATE SIGNED 12/23/66 M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Joseph Shear | | | | 23D. ADDRESS 6715 Park Heights Ave. Balt. 21215 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/24/66 | | 24C. NAME of CEMETERY or CREMATORY Western Cemetery | | 24D. LOCATION (City, town, or county) (State) Edmondson & Longwood - 21223 | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | 25B. NAME OF REGISTRAR E. E. Jackson | | 25C. FUNERAL DIRECTOR ADDRESS Loring Byers-8728 Liberty Rd. Randallstown | | | |

1902

1903

1904

1905

1906

1907

1908

1909

1910

W-300

66 12881

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66 12881

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOSEPH F.

WHITE

2. DATE AND HOUR PRONOUNCED DEAD

December 21, 1966

8:49

A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3816 Sylvan Drive

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

11/13/1919

9. AGE (In years
last birthday)

47

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Sgt.

10B. KIND OF BUSINESS OR INDUSTRY

Md. State Police

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph E. White

14. MOTHER'S MAIDEN NAME

Anna Murr

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

W.W. II

16. SOCIAL
SECURITY NO.

218-05-4968

17. INFORMANT

ADDRESS

21207

Mrs. Alice V. White-3816 Sylvan Dr. Balt. 21207

18. 443X-29035

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Hypertensive and Arteriosclerotic
Cardiovascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Craneo-cerebral Injuries

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

In front of 3816 Sylvan Drive

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
12 21 '66 8:00

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Fell

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/21/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/24/66

23C. NAME of CEMETERY or CREMATORY

Mt. Olivet Cemetery

23D. LOCATION

(City, town, or county)

Frederick, Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Loring Byers-8728 Liberty Rd. Randallstown

WALTER F. POIRCE

5/10/1911

1911

W. F. POIRCE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 12882</u> | |
|--|-------------------------|--|--|--|---|
| BIRTH NO. <u>66 12882</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Anna Cluster</u> | | 2. DATE AND HOUR OF DEATH <u>December 22, 1966</u> <u>11:45 P. M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>3501 St. Paul Streets</u> <u>Marylander Apartments, Apt 723</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>12-02</u> D. STREET ADDRESS (If rural, give location) <u>3501 St. Paul St., Marylander Apts., Apt 723</u> | | | |
| 5. SEX <u>Female</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widow</u> | 8. DATE OF BIRTH <u>May 4, 1903</u> | 9. AGE (In years last birthday) <u>63</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Proprietor</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Theater</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>Albert Friedman</u> | | 14. MOTHER'S MAIDEN NAME <u>Julia ?</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>212-40-2156</u> | | 17. INFORMANT <u>Mrs. Robert Hyman, 6502 Gardenwick Road #9</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) <u>Cancer rectum</u> DUE TO (B) _____ DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>May 12, 1958</u> to <u>Dec 22, 1966</u> , that (I) (we) last saw the deceased alive on <u>Dec 21, 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Joseph D B King</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) <u>Dr. Joseph King</u> | | 23D. ADDRESS <u>222 W. Cold Spring Lane</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12/25/66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Shaarei Tfiloh</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 27 1966</u> | | | |
| 25B. NAME OF REGISTRAR <u>Sol Levinson & Bros. Inc.</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>6010 Reisterstown</u> | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. <u>5136</u> | | 66 12883 | | CERTIFICATE OF DEATH | | Registered No. <u>66 12883</u> | |
|--|--|--|--|---|--|---|--|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) <u>David Schneiderman</u> | | | | | | 2. DATE AND HOUR OF DEATH <u>December 23, 1966</u> <u>8</u> <u>A.</u> <u>M.</u> | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Jewish Convelesant Home</u> | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>6-04</u> D. STREET ADDRESS (If rural, give location) <u>2014 E. Baltimore Street</u> | | | | | |
| 5. SEX <u>Male</u> | | 6. RACE <u>White</u> | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u> | | 8. DATE OF BIRTH | | 9. AGE (In years lost birthday) <u>84</u> | | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Reverend</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Religion</u> | | 11. BIRTHPLACE (State or foreign country) <u>Russia</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Jacob Schneiderman</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>Miriam ?</u> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>219-32-0875A</u> | | 17. INFORMANT <u>Mr. Nathan Schneiderman, 2401 Avenue</u> | | | | ADDRESS <u>Brooklyn, N.Y.</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma Stomach</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 month</u> | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <u>ASCVD</u> | | | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>ASCVD</u> | | | | | | <u>20 years</u> | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1962</u> 19 to <u>12/23/66</u> 19 that (I) (we) last saw the deceased alive on <u>12/21/66</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE <u>Joseph Shear</u> | | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>12/23/66</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>Dr. Joseph Shear</u> | | | | | | 23D. ADDRESS <u>6715 Park Heights Avenue</u> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12/25/66</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Bnai Israel</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 27 1966</u> | | | | 25B. NAME OF REGISTRAR <u>Dr. J. E. Schaefer</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>Sol Levinson & Bros. Inc., 6010 Reist., Rd.</u> | | | | | |

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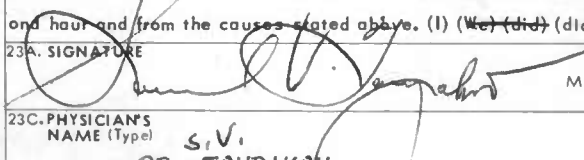
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

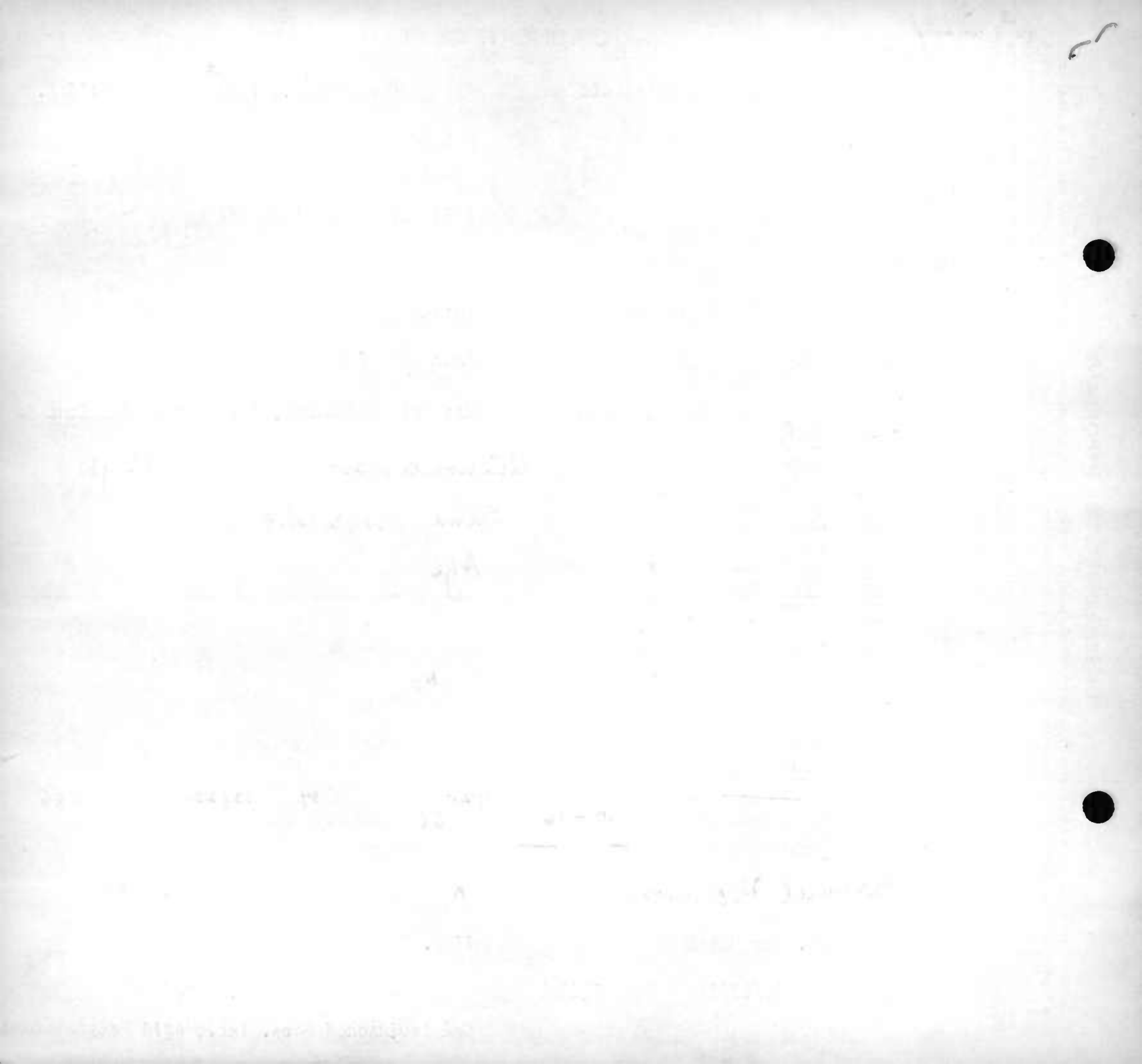
| | | | | | |
|---|---------|--|---|---|---|
| BIRTH NO. 66 12884 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 12884 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | MAX SHLIAN | | DECEMBER 22, 1966 1 10 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | A. STATE B. COUNTY | | |
| 37 MERCY HOSPITAL | | | MARYLAND | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | |
| | | | BALTIMORE | | |
| | | | D. STREET ADDRESS (If rural, give location) | | |
| | | | 3508 LANGREHR ROAD, #7 | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months: Days |
| MALE | WHITE | MARRIED | FEBRUARY 23, 1915 | 51 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| POULTRY STORE | | SELF-EMPLOYED | | BALTIMORE, MARYLAND | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| BENJAMIN SHLIAN | | | IDA ? | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS |
| YES W.W. 11 | | | | | MRS. RUTH SHLIAN, 3508 LANGREHR ROAD #7 |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) DUE TO Acute Myocardial Infarction due to Arteriosclerotic Cardiovascular Disease. | | approximately 2 hrs. |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | NONE | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Mar 1948</u> to <u>Dec 1966</u> , that (I) (we) last saw the deceased alive on <u>Dec 20 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE  | | | | 23B. DATE SIGNED | |
| M.D. <u>DR. TOMPAKOU</u> | | | | <u>Dec 22, 1966</u> | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| S.V. <u>DR. TOMPAKOU</u> | | M.D. <u>3600 PARK HEIGHTS AVE</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| BURIAL | | 12/23/66 | | LIBERTY PARK | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| DEC 27 1966 | | <u>Robert E. Salter</u> | | SOL LEVINSON & BROS., INC., 6010 REIST., RD. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 12885</u> | |
|---|-------------------------|---|---|---|---|
| BIRTH NO. <u>66 12885</u> | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>Baila Belle Weisblatt</u> | | | 2. DATE AND HOUR OF DEATH <u>December 22, 1966</u> <u>4:15 P. M.</u> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>00</u> <u>3911 Seven Mile Lane #8</u> | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>27-20</u> D. STREET ADDRESS (If rural, give location) <u>3911 Seven Mile Lane #8</u> | | |
| 5. SEX <u>Female</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widow</u> | 8. DATE OF BIRTH <u>85</u> | 9. AGE (In years last birthday) <u>85</u> If Under 1 Yr. Months: Days: Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>At Home</u> | 11. BIRTHPLACE (State or foreign country) <u>Russia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME <u>Channah Burak</u> | | | 14. MOTHER'S MAIDEN NAME <u>Anna ?</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>Nonee</u> | 17. INFORMANT <u>Miss Rose Weisblatt, 3911 Seven Mile Lane #8</u> | | |
| 18. <u>450.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) <u>Arteriosclerosis</u> DUE TO (B) <u>Same, progressive</u> DUE TO (C) <u>Age</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs</u> |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>9/20</u> <u>1934</u> to <u>12/22</u> <u>1966</u> , that (I) (we) last saw the deceased alive on <u>10-16</u> <u>1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Samuel Morrison</u> | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>12/23/66</u> |
| 23C. PHYSICIAN'S NAME (Type) <u>Dr. Sam Morrison</u> | | | 23D. ADDRESS M.D. <u>11 E. Chase Street</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12/23/66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Beth Tfiloh</u> | |
| 24D. LOCATION <u>Baltimore, Maryland</u> | | (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 27 1966</u> | | 25B. NAME OF REGISTRAR <u>Sol Levinson & Bros. Inc.</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>6010 Reisterstown</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--|--|--|--|--|
| BIRTH NO. 66 12886 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12886 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) ELIZABETH PURDUM | | 2. DATE AND HOUR OF DEATH DECEMBER 22, 1966 10 38 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY BALTIMORE | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTIMORE | | (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-00 | |
| D. STREET ADDRESS (If rural, give location) 7002 Plymouth Rd. | | 5. SEX FEMALE | | 6. RACE W | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED | | 8. DATE OF BIRTH FEBRUARY 7, 1915 | | 9. AGE (In years last birthday) 51 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) BALTIMORE CITY | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13. FATHER'S NAME LEWIS F. ECKHART | | 14. MOTHER'S MAIDEN NAME GEORGIA ZINK | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 213-14-9962 | | 17. INFORMANT MR. FRANK LEWIS PURDUM, JR. (SON) | |
| 18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction | | CAUSE OF DEATH (A) DUE TO Arteriosclerotic heart disease | | INTERVAL BETWEEN ONSET AND DEATH 6 hr | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | 10 years | |
| (C) DUE TO | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) Dr. H. Schell | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept 1959 to Dec 22 1966, that (I) (we) last saw the deceased alive on Dec 22 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Robert I. Levy | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 12/22/66 | |
| 23C. PHYSICIAN'S NAME (Type) Robert I. Levy | | 23D. ADDRESS 114 Medical Arts, Balt Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-27-66 | | 24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | |
| 24D. LOCATION Baltimore, Maryland | | 24E. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | 24F. NAME OF REGISTRAR E. J. P. [unclear] | |
| 24G. FUNERAL DIRECTOR Ellsworth [unclear] | | 24H. ADDRESS 700 Liberty Hgts. Avenue | | | |

Handwritten signature or text at the bottom of the page.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 12887</u> | |
|---|-------------------------|--|--|--|---|
| BIRTH NO. <u>66 12887</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Jesse Milhiser</u> | | 2. DATE AND HOUR OF DEATH <u>Dec. 24, 66</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Belvedere Nursing Home</u> <u>West Belvedere Avenue</u> | | A. STATE <u>Maryland</u> | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | | |
| | | D. STREET ADDRESS (If rural, give location) <u>2607 West Belvedere Avenue</u> | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Single</u> | 8. DATE OF BIRTH <u>Aug. 20, 1889</u> | 9. AGE (In years last birthday) <u>77</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clothing</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Retired</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Isaac Milhiser</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Mollie Schwab</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes 1917-1919</u> | | | |
| 16. SOCIAL SECURITY NO. <u>216-01-0434</u> | | 17. INFORMANT <u>Mrs. Rose Hoffman 2607 W. Belvedere Ave</u> | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma of Lung</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> | | 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>September 19 66</u> to <u>Dec 12/24 19 66</u> and that (I) (we) last saw the deceased alive on <u>12/24 19 66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Louis Elwoodman</u> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED <u>12/25/66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Robert Louis Goodman</u> M.D. | | | | 23D. ADDRESS <u>2208 Arden Road</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12-27-66</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Baltimore Hebrew</u> | |
| 24D. LOCATION <u>Baltimore, Maryland</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 27 1966</u> | | | |
| 25B. NAME OF REGISTRAR <u>Robert E. Seligson</u> | | 25C. FUNERAL DIRECTOR <u>Minna Ahrens</u> ADDRESS <u>Minna Ahrens 749 Lake Drive</u> | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|--|--|--|--|
| 66 12888 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12888 | |
| BIRTH NO. | | M.E. CASE NO. | | HYMAN | |
| 1. NAME OF DECEASED (Type or Print) | | Eugene Sterling | | 2. DATE AND HOUR OF DEATH Dec. 20. 66 10.38 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY | | 5. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| H2SINAI HOSPITAL | | Md | | 27-20 | |
| 6. SEX M | | 7. RACE W | | 8. MARIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single | |
| 9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10. KIND OF BUSINESS OR INDUSTRY | | 11. DATE OF BIRTH | |
| Lawyer | | Social Security | | 9.21.10 | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. BIRTHPLACE (State or foreign country) | | 14. AGE (In years last birthday) | |
| U.S.A. | | Chicago, Illinois | | 56 | |
| 15. FATHER'S NAME | | 16. MOTHER'S MAIDEN NAME | | 17. INFORMANT | |
| Morris Sterling | | Eva Ackerman | | Mrs. Eva Sterling, 3717 Midheights Avenue | |
| 18. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 19. SOCIAL SECURITY NO. | | 20. ADDRESS | |
| No | | Unknown | | 3717 Midheights Avenue | |
| 21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | 22. CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | 23. INTERVAL BETWEEN ONSET AND DEATH | |
| Myocardial Infarct. | | Cardiac Arrest | | | |
| 24. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | 25. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 26. DATE OF OPERATION | | 27. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 28. AUTOPSY? (Yes or No) | |
| 0 | | | | | |
| 29. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 30. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 31. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 32. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 33. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 34. HOW DID INJURY OCCUR? | |
| 35. I certify that (I) (this hospital) attended the deceased from 12.20.1966 to 12.20.1966, that (I) (we) lost saw the deceased alive on 12/20/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 36. SIGNATURE R. Theodore | | 37. DATE SIGNED 12/20/66 | |
| 38. PHYSICIAN'S NAME (Type) | | 39. ADDRESS | | 40. M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | |
| ROGER T. HEADORE | | Sinai Hospital | | | |
| 41. BURIAL CREMATION, REMOVAL (Specify) | | 42. DATE | | 43. NAME of CEMETERY or CREMATORY | |
| Burial | | 12/22/66 | | George Washington | |
| 44. DATE REC'D BY HEALTH DEPT. | | 45. NAME OF REGISTRAR | | 46. FUNERAL DIRECTOR | |
| DEC 27 1966 | | J. E. J. J. J. | | Sol Levinson & Bros. Inc., 6010 Reisterstown | |
| 47. LOCATION (City, town, or county) | | 48. STATE | | | |
| Hyattsville, Maryland | | | | | |

Letter from Sinai Hospital 1-3-67 M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 12889 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 66 12889 | |
|--|---------|--|-----------------------------------|---|---|--|------------------------------|----------------------------------|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | | | |
| (Type or Print) MARY JEANNE COATES | | | | | | 12/19/66 | | 7:20 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE | | B. COUNTY | | | |
| UNIVERSITY HOSPITAL | | | | MARYLAND | | Baltimore | | | |
| 38 | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | BALTIMORE #28 | | 53-00 | |
| | | | | D. STREET ADDRESS (If rural, give location) | | 231 GLEN MORE AVE. | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| F | W | MARRIED | 5/17/27 | 39 | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | |
| CLERK | | | BUREAU of S.S. REGISTRATION | | NORTH DAKOTA | | U.S. | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| HENRY CHARLES SINCLAIR COLE | | | | SINCLAIR, MARJORIE | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | |
| No | | | | | Henry Sinclair Jr. 231 Glenmore Ave | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) INTRA CEREBRAL HEMORRHAGE | | | | 9 hrs | |
| ANTECEDENT CAUSES | | | | (B) HYPERTENSION | | | | years | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 2 | | | | YES | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec 19 19 66 to Dec 19 19 66, that (I) (we) last saw the deceased alive on DEC 19 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | | | |
| MORTON D. KRAHER | | | | 12/19/66 | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | | | |
| MORTON D. KRAHER | | | | UNIVERSITY HOSPITAL | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | | |
| Burial | | 12-22-66 | | Baltimore International Cem. | | Baltimore Ind. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | | | |
| DEC 27 1966 | | Robert E. Johnson | | John J. Conway | | 231 Glenmore Ave | | | |

UNIVERSITY HOSPITAL

W
MARRIED
BORN 1/25
RESIDENT

~~CLARK~~ CLARK

—

UNIVERSITY HOSPITAL

CLARK

CLARK

SINGAPORE - HOSPITAL

UNIVERSITY HOSPITAL

INTER-CORPORATE HOSPITAL

HYPERTENSION

Yes

Dec 11

CLARK

X

UNIVERSITY HOSPITAL

HINDS D KENNEDY

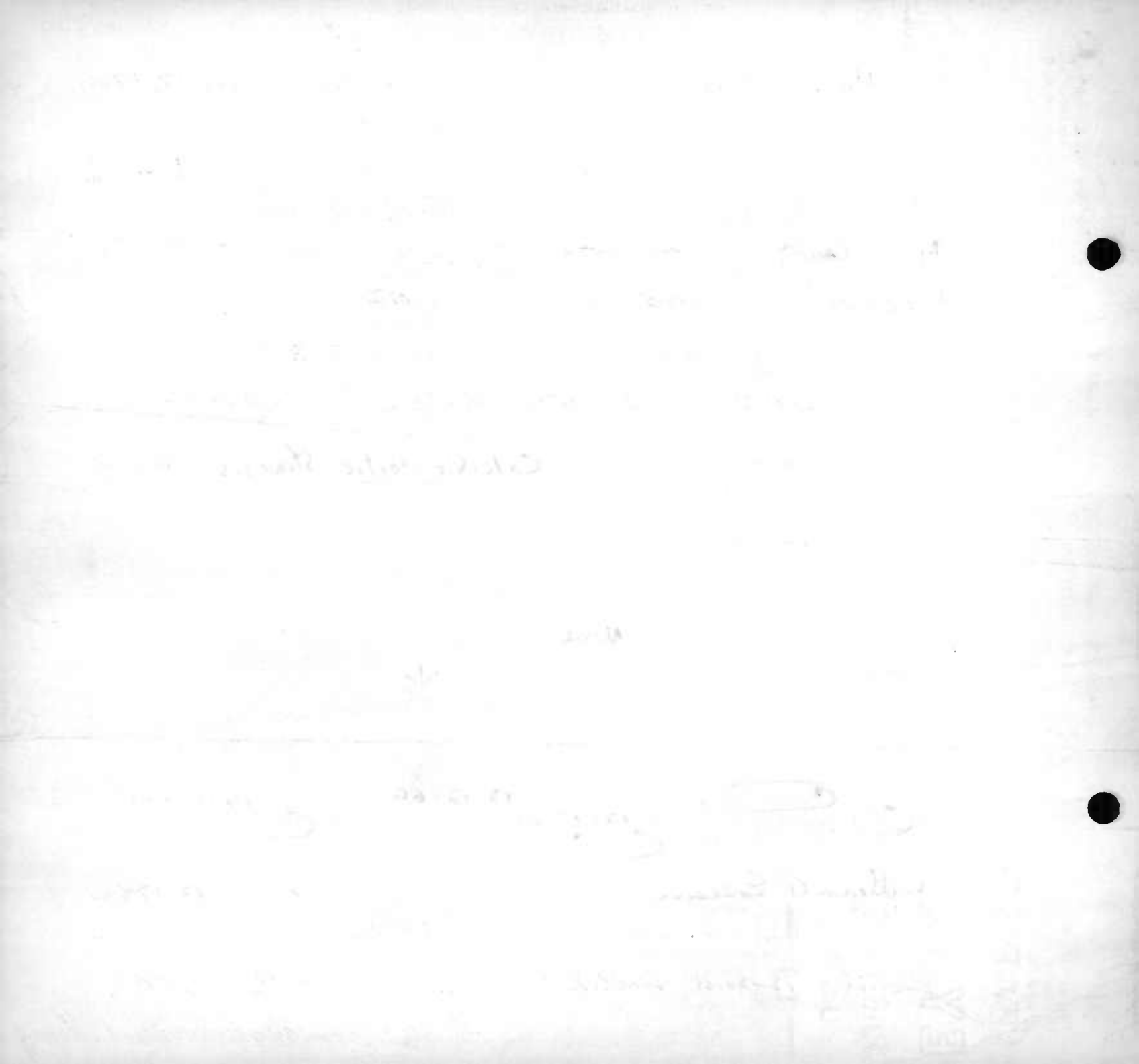
CLARK

CLARK

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12890 | |
|---|-------------------------|---|------------------------------------|---|--|
| BIRTH NO. 66 12890 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Muhl, William H.</i> | | 2. DATE AND HOUR OF DEATH <i>4:20 AM Dec 17, 1966</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>ARIZONA</i> B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>THE JOHNS HOPKINS HOSPITAL</i> <i>33</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>SCOTTSDALE</i> <i>V-02</i> | | | |
| | | D. STREET ADDRESS (If rural, give location) <i>7402 EAST MORELAND ST</i> | | | |
| 5. SEX <i>M</i> | 6. RACE <i>Cauc.</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>MARRIED</i> | 8. DATE OF BIRTH <i>11-4-95</i> | 9. AGE (In years last birthday) <i>71</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>AGENT</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>INB. CO.</i> | | 11. BIRTHPLACE (State or foreign country) <i>MD.</i> | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME <i>WILLIAM MUHL</i> | | 14. MOTHER'S MAIDEN NAME <i>FLORENCE HADEL</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>YES WWI</i> | | 16. SOCIAL SECURITY NO. <i>212-10-7971</i> | | 17. INFORMANT <i>Mr. Agnes Turner - 31 First Lane</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <i>Calcific Aortic Stenosis</i> | | CAUSE OF DEATH (A) <i>Calcific Aortic Stenosis</i> (B) <i>DUE TO</i> (C) <i>DUE TO</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>None</i> | | | | | |
| 19A. DATE OF OPERATION <i>12-12-66</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>No</i> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from <i>12-12-66</i> 19 to <i>12-17-66</i> 19, that (I) (we) last saw the deceased alive on <i>12-17-66</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <i>William A. Emerson</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>12-17-66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>WILLIAM A. EMERSON</i> | | M.D. | | 23D. ADDRESS <i>THE JOHNS HOPKINS HOSPITAL</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12-22-66</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Bella National Cem.</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Bald - Ind</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 27 1966</i> | | 25B. NAME OF REGISTRAR <i>John E. Tolson</i> | |
| 25C. FUNERAL DIRECTOR <i>Forley - Carrough Funeral Home</i> | | ADDRESS | | | |



1
R-25366 12891
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 12891

M.E. CASE NO.

| | | | | | | | |
|--|------------------|---|--|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR PRONOUNCED DEAD | | | |
| RAYMOND J. ROSENDALE | | | | December 17, 1966 9:14 P M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinai Hospital | | | | A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 29-41 D. STREET ADDRESS (If rural, give location) 5511 Elderon Avenue | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH MARCH 21, 1908 | 9. AGE (In years last birthday) 58 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ACCOUNTANT | | 10B. KIND OF BUSINESS OR INDUSTRY BLDG + LOAN | | 11. BIRTHPLACE (State or foreign country) MD. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME ALOYSIUS ROSENDALE | | | | 14. MOTHER'S MAIDEN NAME NELLIE DIWNEY | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Leo Rosendale - 635 Mt. Ridge Rd. | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E 819.41 Craniocerebral Injury. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Cold Spring Lane, W. of Jones Falls Cutoff 27-15 | | | |
| 21D. TIME OF INJURY (APPROX.) 12 17 '66 P | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? Driver of auto into fixed object. | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Petty | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 12-22-66 | 23C. NAME OF CEMETERY or CREMATORY Cathedral Cem. | | 23D. LOCATION (City, town, or county) (State) Bald. Md. | | |
| 24A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | 24B. NAME OF REGISTRAR J. E. Tolson | | 24C. FUNERAL DIRECTOR ADDRESS J. E. Tolson - 635 Mt. Ridge Rd. | | | |

2074.525014

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© 2005

$$440.8 + 26.15$$

AT-02012 K0101-DAT

66 12892

BALTIMORE CITY HEALTH DEPARTMENT

66 12892

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ALBERT

POLAND

(POLOTSKY)

2. DATE AND HOUR PRONOUNCED DEAD

December 21, 1966

1:45 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 1442 N. Broadway

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4917 Edgemere Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

March 12, 1904

9. AGE (In years
last birthday)

62

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Employee

10B. KIND OF BUSINESS OR INDUSTRY

Tavern

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Brishore Polotsky

14. MOTHER'S MAIDEN NAME

Ethel ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

218-07-9720

17. INFORMANT

Mrs. Eva Poland, 4917 Edgemere Avenue

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Close Range Gunshot Wound of Head
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Store

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

1442 N. Broadway

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
12 21 '66 1:35A

21E. INJURY OCCURRED

WHILE AT
WORK ☒NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

Was shot during a hold-up

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breiteneker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/21/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/22/66

23C. NAME of CEMETERY or CREMATORY

Bnai Israel

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Sol Levinson & Bros. Inc., 6010 Reisterstown

[Faint, illegible signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12893 | |
|---|-------------------------|--|------------------|--|---|
| BIRTH NO. 66 12893 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Sarah Schiller</i> | | 2. DATE AND HOUR OF DEATH <i>December 20, 1966</i> 9 A. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE <i>Maryland</i> B. COUNTY <i>27-20</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | |
| D. STREET ADDRESS (If rural, give location) <i>2907 Fallstaff Road, Apt 24</i> | | | | | |
| 5. SEX <i>Female</i> | 6. RACE <i>White</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widow</i> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) <i>73</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>At Home</i> | | 11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 13. FATHER'S NAME <i>Henry Zeller</i> | | 14. MOTHER'S MAIDEN NAME <i>Rebecca ?</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>Unknown</i> | | 17. INFORMANT <i>I. Harold Hammerman, 10 Light Street #2</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) DUE TO <i>Coronary Thrombosis</i> (B) DUE TO <i>Arteriosclerotic Heart Disease</i> (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH <i>immediately</i> <i>years</i> | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Jan 1964</i> to <i>present</i> 19 <i>64</i> that (I) (we) last saw the deceased alive on <i>11/21/66</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (<u>did</u>) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Bernard Bergin</i> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>12/20/66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Bernard Bergin</i> | | 23D. ADDRESS <i>6721 Reisterstown Rd. Balto. 15, Md.</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12/22/66</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Beth Tiloah</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 27 1966</i> | | | |
| 25B. NAME OF REGISTRAR <i>Robert E. Johnson</i> | | 25C. FUNERAL DIRECTOR <i>Sol Levinson & Bros. Inc., 6010 Reisterstown</i> | | | |

ATTN

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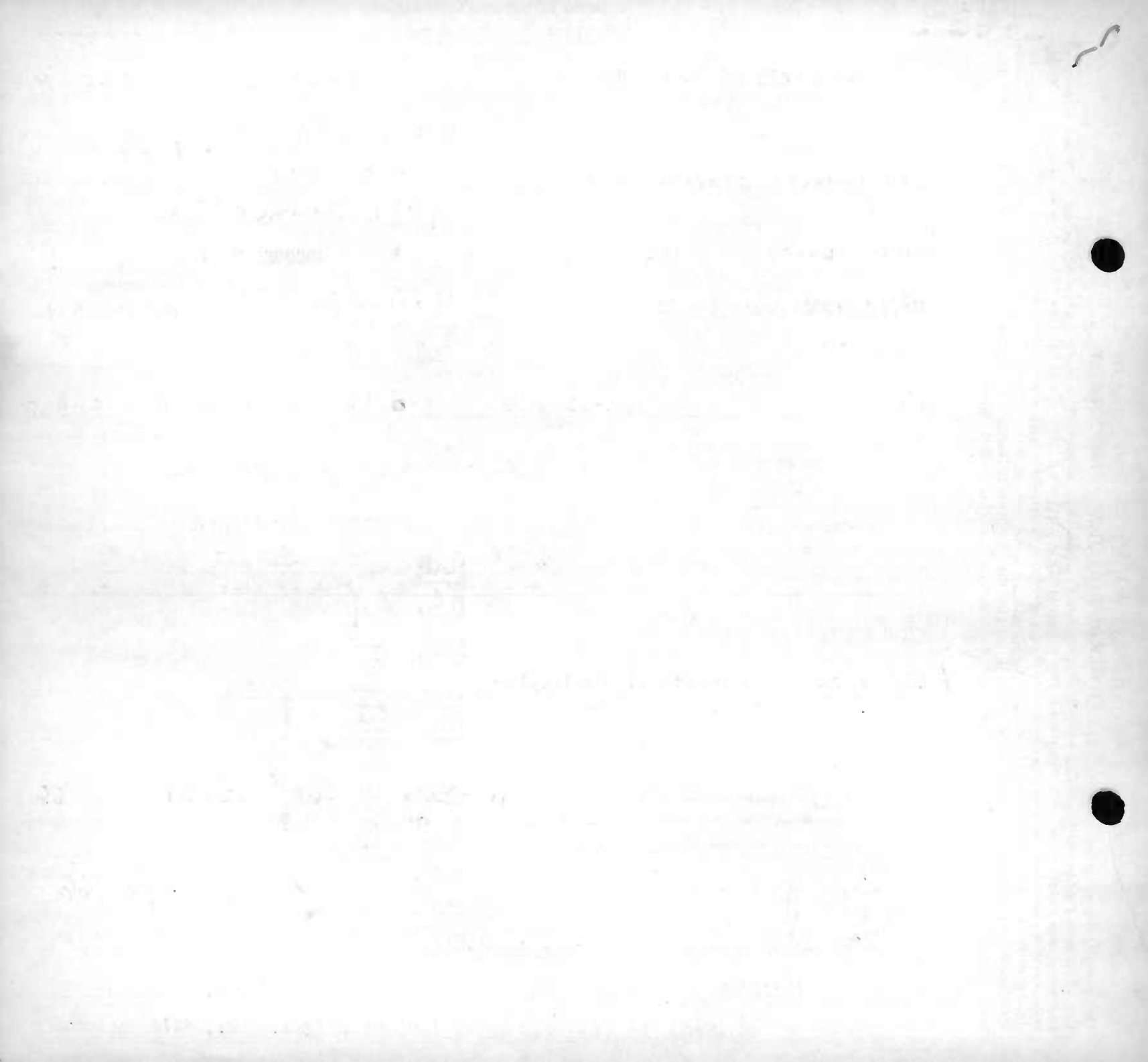
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12894 | |
|--|---------------|--|---|--|--|
| BIRTH NO. 66 12894 | | CERTIFICATE OF DEATH | | Registered No. 66 12894 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) SCHWARTZ ROSE MAM | | 2. DATE AND HOUR OF DEATH 12-21-66 3:45 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE MARYLAND | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | B. COUNTY | |
| NORTH CHARLES GENERAL HOSPITAL | | BALTIMORE | | 15-09 | |
| 49 | | D. STREET ADDRESS (If rural, give location) | | 4019 Bonner Rd. | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH | 9. AGE (In years last birthday) 82 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife At Home |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? | |
| ROMANIA | | | ROMANIA | AMERICAN | |
| 13. FATHER'S NAME Morris Cohen | | 14. MOTHER'S MAIDEN NAME Rifka ? | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 162-03-5155 | | 17. INFORMANT ADDRESS North CHARLES GEN. Hosp. CHART | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES | | (A) DUE TO Congestive heart failure | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO Hypoproteinaemia. Anaemia. | | | |
| II | | (C) DUE TO Intestinal obstruction due to carcinoma of the colon | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 12/14/66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Intestinal Obstruction | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 11-28 1966 to 12-21 1966, that (1) (we) last saw the deceased alive on 12-21 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Dr. Juven F. Oleman M.D. | | 23B. DATE SIGNED 12/21/66 | | 23C. PHYSICIAN'S NAME (Type) DR. Mariou Friedmann M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/22/66 | | 24C. NAME OF CEMETERY or CREMATORY Forband | |
| 24D. LOCATION Baltimore, Maryland | | 24E. ADDRESS Sol Levinson & Bros. Inc., 6010 Reisterstown | | 24F. DATE REC'D BY HEALTH DEPT. | |
| 24G. NAME OF REGISTRAR | | 24H. FUNERAL DIRECTOR | | 24I. ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|--|-----------|--|------------------|--|---|
| BIRTH NO. 66 12895 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12895 | |
| M.E. CASE NO. H. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) PAULINE PARMER | | 2. DATE AND HOUR OF DEATH 12/21/66 5 ³⁰ AM | | M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL OF BALTO. | | A. STATE MARYLAND | | | |
| | | B. COUNTY | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | 27-17 | |
| | | D. STREET ADDRESS (If rural, give location) 2407 W. ROGERS AVE | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOW | 8. DATE OF BIRTH | 9. AGE (In years last birthday) 80 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY At Home | | 11. BIRTHPLACE (State or foreign country) NEW YORK CITY | |
| 13. FATHER'S NAME ELI BERNSTEIN | | 14. MOTHER'S MAIDEN NAME Sarah Balyis | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT ADDRESS S. JANE LAKE 4604 HARTWICK RD. COLLEGE PARK, MD. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 293X I | | CAUSE OF DEATH CARDIAC ARRYTHMIA AND FAILURE | | INTERVAL BETWEEN ONSET AND DEATH 9 DA.- | |
| (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO ANEMIA | | ~ 1 MO. | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/10 to 12/21 1966 that (I) (we) lost saw the deceased alive on 12/21 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Sheldon M. Frank | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/21/66 | |
| 23C. PHYSICIAN'S NAME (Type) SHELDON M. FRANK | | M.D. 23D. ADDRESS SINAI HOSPITAL OF BALTO.- | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/23/66 | | 24C. NAME OF CEMETERY or CREMATORY New Har Sinai | |
| | | | | 24D. LOCATION (City, town, or county) (State) Garrison, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | 25B. NAME OF REGISTRAR Sol Levinson & Bros. Inc. | | 25C. FUNERAL DIRECTOR ADDRESS 6010 Reisterstown | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. 66 12896 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12896 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Manko, Dora | | 2. DATE AND HOUR OF DEATH PM. 3:30. Dec 16 1966 3:30 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-15 D. STREET ADDRESS (If rural, give location) 6158 Green Meadow Parkway | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 12-24-99 | 9. AGE (In years last birthday) 66 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY at Home | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME EMANUEL Mendelsohn | | 14. MOTHER'S/MAIDEN NAME Sarah Simon | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 214-40-3006 | | 17. INFORMANT Edward Manko - 6158 Green Meadow | |
| 18. 576X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) peritonitis. | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO | | (B) DUE TO | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (C) | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (<u>this hospital</u>) attended the deceased from Dec 13 1966 to Dec 16 1966 , that (I) (<u>we</u>) last saw the deceased alive on 3:30 pm Dec 16 1966 and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>We</u>) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Sang Won Song | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED Dec 16, 1966 | |
| 23C. PHYSICIAN'S NAME (Type) DR. SANG WON SONG | | 23D. ADDRESS THE UNION MEMORIAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Dec 18/66 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore Hebrew | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md | | 25A. DATE REC'D BY HEALTH DEPT. DEC 17 1966 | | 25B. NAME OF REGISTRAR Sal Leonard | |
| 25C. FUNERAL DIRECTOR Sal Leonard | | 25D. ADDRESS 6010 Reister Rd | | | |

12/4/67 - no change - see letter from Union News. Keep -
in Doc's file - Bureau of Reclamation
American ridge

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 12897 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12897 | |
|--|-------------------------|--|-------------------------------------|--|----------------------------|--|--|
| CERTIFICATE OF DEATH | | | | | | | |
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) <i>David Berger</i> | | 2. DATE AND HOUR OF DEATH <i>12/19/66</i> <i>10:55 A.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND <i>Sinai Hospital of Baltimore Inc</i> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | | | D. STREET ADDRESS (If rural, give location) <i>2911 Violet Ave</i> | | | |
| 5. SEX <i>Male</i> | 6. RACE <i>White</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i> | 8. DATE OF BIRTH <i>12/19/66</i> | 9. AGE (In years last birthday) <i>69</i> | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Tailor</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Shop</i> | | 11. BIRTHPLACE (State or foreign country) <i>Lithuania</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>Unknown</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Unknown</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>Unknown</i> | | 17. INFORMANT <i>Mrs. Mary Berger</i> | | ADDRESS <i>2911 Violet Ave</i> | |
| 18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) <i>Myocardial Infarction</i> DUE TO | | INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i> | |
| | | | | (B) <i>Coronary Insufficiency</i> DUE TO | | <i>Unknown</i> | |
| | | | | (C) <i>ASCD</i> | | <i>Unknown</i> | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not White <input type="checkbox"/> Work At Work | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>1966</i> to <i>12/19/1</i> 19 <i>66</i> . that (I) (we) last saw the deceased alive on <i>19 66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>W. Cieplinski</i> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>12/19/66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>William Cieplinski</i> | | | | 23D. ADDRESS M.D. <i>Sinai Hospital of Baltimore</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Removal</i> | | 24B. DATE <i>Dec 20/66</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Workmen Circle</i> | | 24D. LOCATION (City, town, or county) (State) <i>Norfolk, Va</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 27 1966</i> | | 25B. NAME OF REGISTRAR <i>Sal Spunier</i> | | 25C. FUNERAL DIRECTOR <i>Sal Spunier</i> | | ADDRESS <i>6000 Rest Road</i> | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. <u>66 12898</u> | |
| BIRTH NO. <u>66 12898</u> | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH <u>12-22-66</u> <u>2:30</u> A.M. | |
| 1. NAME OF DECEASED (Type or Print) <u>ZAMANSKY, NELDA FREDA</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE Co.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>42 SINAI HOSP.</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>2908 SMITH AVE.</u> | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>NEVER MARRIED</u> | 8. DATE OF BIRTH <u>10-31-32</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bakery</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Self-Employed</u> | 9. AGE (In years last birthday) <u>34</u> |
| 13. FATHER'S NAME <u>SAMUEL Zamansky</u> | | 11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MARYLAND</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>211-34-2837</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> |
| 14. MOTHER'S MAIDEN NAME <u>Bessie Diamond</u> | | 17. INFORMANT <u>HOSP. CHART</u> | |
| 18. <u>392X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) <u>CHRONIC RENAL FAILURE</u> DUE TO (B) <u>CHRONIC GLOMERULONEPHRITIS?</u> DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3 YRS.</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>RECURRENT PULM. INFECTIONS</u> | | 31 YRS. | |
| 19A. DATE OF OPERATION <u>2</u> | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ | 20A. AUTOPSY? (Yes or No) <u>YES</u> | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u> | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____ | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____ | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> Work <input type="checkbox"/> At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? _____ | |
| 22. I certify that (I) <u>this hospital</u> attended the deceased from <u>12-12-66</u> to <u>12-22-66</u> , that (I) <u>we</u> last saw the deceased alive on <u>12-22-66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>We</u> (did) <u>did not</u> view the body after death. | | | |
| 23A. SIGNATURE <u>Alvin Schachter</u> | | 23B. DATE SIGNED <u>12-22-66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>ALVIN SCHACHTER</u> | | 23D. ADDRESS <u>SINAI HOSP.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | 24B. DATE <u>12/23/66</u> | 24C. NAME of CEMETERY or CREMATORY <u>Beth Tfiloh</u> | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 27 1966</u> | 25B. NAME OF REGISTRAR <u>Robert E. Teflon</u> | 25C. FUNERAL DIRECTOR ADDRESS <u>Sol Levinson & Bros. Inc., 6010 Reisterstown</u> | |



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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12899 | |
|--|-------------------------|---|--|--|--|
| BIRTH NO. 66 12899 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED <i>Marc Taingiu</i> | | 2. DATE AND HOUR OF DEATH <i>Dec 20 / 66</i> <i>10:30 A.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>3316 Royce Ave</i> | | A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>27-16</i> D. STREET ADDRESS (If rural, give location) <i>3316 Royce Ave</i> | | | |
| 5. SEX <i>Male</i> | 6. RACE <i>White</i> | 7. MARRIED, NEVER MARRIED <i>Married</i> | 8. DATE OF BIRTH <i>Oct 16, 1907</i> | 9. AGE (In years last birthday) <i>59</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chemist</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Industrial</i> | | 11. BIRTHPLACE (State or foreign country) <i>Rumania</i> | |
| 13. FATHER'S NAME <i>Benjamin Hess Taingiu</i> | | | 14. MOTHER'S MAIDEN NAME <i>Freda</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Mahina Taingiu</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>151X1</i> | | CAUSE OF DEATH (A) <i>Carcinoma of stomach</i> (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH <i>About 1 yr</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>12/17</i> 19 <i>66</i> to <i>12/19/</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>12/19/</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (I) (We) <input checked="" type="checkbox"/> (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>R. Weinberger</i> | | | | 23B. DATE SIGNED <i>12/20/66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>R. Weinberger</i> | | | | 23D. ADDRESS <i>3640 Fords Lane - Baltimore 21215</i> | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>Dec 21/66</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>CHITZUS AMUNO</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 27 1966</i> | | | |
| 25B. NAME OF REGISTRAR <i>Paul E. Tolson</i> | | 25C. FUNERAL DIRECTOR <i>Sal Lennon & Sons - 6010 Reest Rd.</i> | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. 66 12900 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12900 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED Chiодо Joseph Lewis | | 2. DATE AND HOUR OF DEATH Dec. 20-66 9.45 P.M. | |
| 3. PLACE OF DEATH N. BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Baltimore B. COUNTY Maryland | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) 1-62 | |
| FULL NAME OF HOSPITAL OR INSTITUTION North Charles General Hospital | | D. STREET ADDRESS (If rural, give location) 129 S. Robinson Street | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH 11-21-06 | 9. AGE (In years last birthday) 60 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most working life, even if retired) machinist | | 10B. KIND OF BUSINESS OR INDUSTRY Bethlem Steel Co. | | 11. BIRTHPLACE (State or foreign country) Italy W. Va. | |
| 12. CITIZEN OF WHAT COUNTRY? American | | 13. FATHER'S NAME Frank Chiодо | | 14. MOTHER'S MAIDEN NAME Carmela Demasi | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 213-09-4363 | | 17. INFORMANT patient | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Ca bladder | | 19. CAUSE OF DEATH (A) DUE TO Uremia (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 12-1-66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca bladder | | 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 11/22/66 to 12-20-66, that (I) (we) last saw the deceased alive on 12-22-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Carmela Stella | | M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-22-66 | |
| 23C. PHYSICIAN'S NAME (Type) CARMELA STELLA | | 23D. ADDRESS N. Charles Gen. Hosp. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/24/66 | | 24C. NAME OF CEMETERY or CREMATORY Oaklawn Cem. | |
| 24D. LOCATION (City, town, or county) (State) Baltimore Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. 12-22-66 | | 25B. NAME OF REGISTRAR Joseph N. Zuvino | | 25C. FUNERAL DIRECTOR Joseph N. Zuvino | |
| 25D. ADDRESS 3030 College St. | | | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. 66 12901 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12901 | |
| 1. NAME OF DECEASED (Type or Print) ELAINE BURGAMY | | | 2. DATE AND HOUR OF DEATH L 12/22/66 7:15 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 THE JOHNS HOPKINS HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 26-08 D. STREET ADDRESS (If rural, give location) 3509 MT. PLEASANT AVENUE | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | B. DATE OF BIRTH 11/15/31 | 9. AGE (In years lost birthday) 35 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Balto. Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME JAMES TALLEGSEN | | | 14. MOTHER'S MAIDEN NAME ELIZABETH SCHMIDT | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 218-26-5466 | 17. INFORMANT Mr. William Burgamy | | ADDRESS Same |
| 18. 410X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) Aortic insufficiency, mitral stenosis DUE TO (B) Subacute bacterial endocarditis DUE TO (C) Rheumatic heart disease | | INTERVAL BETWEEN ONSET AND DEATH 6 years |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 1. 10/24/66 2. 12/30/66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 1. Aortic insuff. + mitral stenosis 2. Replacement infected prosthetic valve | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/1 19 66 to 12/22 19 66 , that (I) (we) last saw the deceased alive on 7:15 AM 12/22 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death. | | | | | |
| 23A. SIGNATURE Jerry S. Dorman | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 12/22/66 |
| 23C. PHYSICIAN'S NAME (Type) JERRY DORMAN | | | 23D. ADDRESS M.D. THE JOHNS HOPKINS HOSPITAL | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 12-26-66 | 24C. NAME of CEMETERY or CREMATORY Oaklawn Cem | | 24D. LOCATION (City, town, or county) (State) Balto Md | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | 25B. NAME OF REGISTRAR Joseph D. Zanner | 25C. FUNERAL DIRECTOR Joseph D. Zanner | | ADDRESS 263 S. Conlin | |

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ELIZABETH SCHMIDT

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Prof. 2. Brown

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---|---------------------|---|------------------------------------|---|--|
| BIRTH NO. 66 12902 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12902 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Toskes, Mrs Frances</i> | | 2. DATE AND HOUR OF DEATH <i>12/21/66 at 3:30 p.m.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>26-05</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Church Home Hospital</i> <i>35</i> | | D. STREET ADDRESS (If rural, give location) <i>615 Umbra St.</i> | | | |
| 5. SEX <i>F</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i> | 8. DATE OF BIRTH <i>9/19/33</i> | 9. AGE (In years lost birthday) <i>33</i> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>- - -</i> | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>American</i> | | 13. FATHER'S NAME <i>Roy Wolfe</i> | | 14. MOTHER'S MAIDEN NAME <i>Unknown</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>MICHAEL TOSKES 615 Umbra St.</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Pulmonary Edema</i> | | CAUSE OF DEATH (A) DUE TO <i>Pulmonary Infarction</i> (B) DUE TO <i>Pulmonary Thrombophlebitis</i> (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH <i>Few days</i> | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Pers. Pneumonia</i> | | | |
| 19A. DATE OF OPERATION <i>12/18/66</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Exploratory Laparotomy</i> | | 20A. AUTOPSY? (Yes or No) <i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this Hospital) attended the deceased from <i>12-17</i> 19 <i>66</i> to <i>12-21</i> 19 <i>66</i> , that (I) (we) lost saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Jose G. Ortiz</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>12-21-66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Jose G. Ortiz</i> | | 23D. ADDRESS M.D. <i>Joseph N. Zannino 263 S. Conkling</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12/23/66</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Holy Redeemer</i> | |
| 24D. LOCATION <i>Baltimore Md.</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 27 1966</i> | | 25B. NAME OF REGISTRAR <i>John E. Redburn</i> | |
| 25C. FUNERAL DIRECTOR <i>Joseph N. Zannino</i> | | ADDRESS <i>263 S. Conkling</i> | | | |

1950-1951

Chief Clerk - H. H. H.

Mr. H. H. H.

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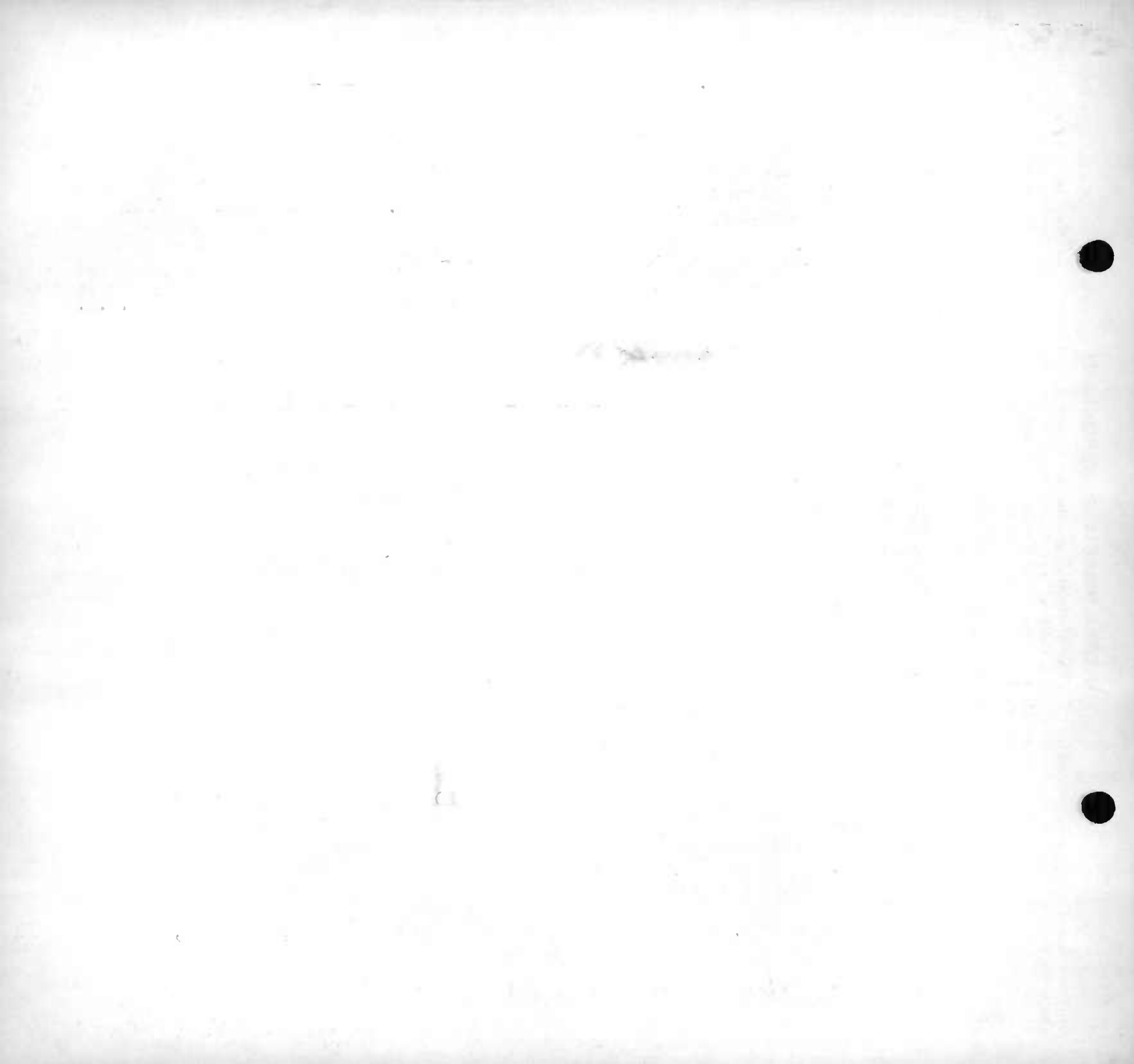
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. 66 12903 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12903 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) HARRY N. UDEGRAFF | | 2. DATE AND HOUR OF DEATH 12-21-1966 2 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | D. STREET ADDRESS (If rural, give location) 3733 Mt. Pleasant Avenue 21224 | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 3-2-1878 | 9. AGE (In years last birthday) 88 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Samuel Updegraff | | 14. MOTHER'S MAIDEN NAME Isabell Mitchell | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 219-01-9502-A | | 17. INFORMANT Records: BCH-4940 Eastern Avenue 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) RECURRENT PULMONARY EMBOLI (B) DUE TO (C) CHRONIC BRONCHITIS | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (This hospital) attended the deceased from 12/20/66 19 to 12/21/66 19 that (1) (we) last saw the deceased alive on 12/21/66 19 and that in my (aur) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Bruce M. Dow | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/21/66 | |
| 23C. PHYSICIAN'S NAME (Type) Bruce M. Dow | | 23D. ADDRESS M.D. 4940 Eastern Avenue, Baltimore, Maryland 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/24/66 | | 24C. NAME OF CEMETERY or CREMATORY Gardens of Faith | |
| 24D. LOCATION Baltimore, Md. | | 24E. CITY, town, or county Baltimore | | 24F. STATE Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | 25B. NAME OF REGISTRAR J. E. [unclear] | | 25C. FUNERAL DIRECTOR Joseph N. Zucino | |
| 25D. ADDRESS 163 S. Carroll St. | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 12904 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12904 | |
|--|--|--|--|--|--|--|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) <u>John R. Hoffeld</u> | | 2. DATE AND HOUR OF DEATH <u>Dec 21, 1966</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | M. STATE | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>3813 Mt. Pleasant Ave</u> | | | | A. STATE <u>MD</u> | | B. COUNTY | |
| 5. SEX <u>M</u> | | | | 6. RACE <u>W</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u> | |
| 8. DATE OF BIRTH <u>JAN 2, 1897</u> | | | | 9. AGE (In years last birthday) <u>69</u> | | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABOR</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u> | | 11. BIRTHPLACE (State or foreign country) <u>BALTO. MD</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | 13. FATHER'S NAME <u>RICHARD</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>CHARLOTTE MICHAELS</u> | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>WWI</u> | | | |
| 16. SOCIAL SECURITY NO. <u>212-09-5898</u> | | | | 17. INFORMANT <u>MRS Adelaide L. Hoffeld</u> | | | |
| 18. <u>443X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH (A) <u>Pulmonary Embolism sudden</u> DUE TO (B) <u>Thrombophlebitis 7-10 days</u> DUE TO (C) <u>arteriosclerotic C.V.D. 5 years</u> <u>Hypertensive C.V.D. 10 years</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION <u>0</u> | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>10/18</u> 19 <u>66</u> to <u>12/21</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12/19</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Isadore K. Grossman</u> | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>12/23/66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Isadore K. Grossman</u> | | | | 23D. ADDRESS <u>1527 E. North Ave</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>12/27/66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Baltimore National Cem</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore MD</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 27 1966</u> | | 25B. NAME OF REGISTRAR <u>Joseph R. Zannini</u> | | 25C. FUNERAL DIRECTOR <u>2635</u> | | ADDRESS <u>2635</u> | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|--|---|--|--|
| BIRTH NO. 66 12905 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12905 | |
| M.E. CASE NO. | | | 1. NAME OF DECEASED (Type or Print) Ellenberger, Mary | | |
| 2. DATE AND HOUR OF DEATH 12/23/66 9:25 a.m. | | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | D. STREET ADDRESS (If rural, give location) 1101 Webb Court | | |
| 5. SEX F | | 6. RACE C | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Divorced | |
| 8. DATE OF BIRTH 1897 March 8, 1898 | | 9. AGE (In years last birthday) 68 69 | | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (State or foreign country) Penna. | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME John Smith | | 14. MOTHER'S MAIDEN NAME Flora Adams | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No -- | | 16. SOCIAL SECURITY NO. 216-54-3717 | | 17. INFORMANT ADDRESS Vivian Nunamaker 5708 Falls Rd. 21209 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH (A) (Cardiac arrest) from ASCVD DUE TO | | INTERVAL BETWEEN ONSET AND DEATH yrs. | |
| ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.) | | (B) Electrolyte imbalance (hyponatremia) DUE TO | | 10 days. | |
| | | (C) Diabetes Mellitus | | yrs. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Recurrent pulmonary emboli | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/27/66 19 to 12/23/66 19 that (I) (we) last saw the deceased alive on 12/23/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Clarence H. Brown, III M.D. | | | | 23B. DATE SIGNED 12/23/66 | |
| 23C. PHYSICIAN'S NAME (Type) Clarence H. Brown, III M.D. | | | | 23D. ADDRESS The Johns Hopkins Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/27/66 | | 24C. NAME OF CEMETERY or CREMATORY Ebenezer Meth. Ch. Cemetery Baltimore Co., Maryland | |
| 24D. LOCATION (City, town, or county) (State) | | 25A. DATE REC'D BY HEALTH DEPT. | | | |
| 25B. NAME OF REGISTRAR James E. Bruzdinski | | 25C. FUNERAL DIRECTOR ADDRESS James E. Bruzdinski 1407 Eastern Ave. #21 | | | |

1/3/67 - Form from funeral director.

ABC

66 12906

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66 12906

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

PAUL W. GRAY, JR.

2. DATE AND HOUR PRONOUNCED DEAD

December 23, 1966

7:10 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Greenspring Avenue & Keyworth

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2556 Quantico Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

5-1-40

9. AGE (in years
last birthday)

26

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Paul W. Gray, Sr.

14. MOTHER'S MAIDEN NAME

Dorothy Stokes

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

yes

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Dorothy Gray 2731 Giles Rd.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Cerebrocranial injuries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Greenspring Avenue & Keyworth

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
12-23-66 ?

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Driver of car which
presumably struck rock

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

December 23, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12-27-66

23C. NAME of CEMETERY or CREMATORY

Baltimore National

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Marshall W. Jones, Jr. 1735 Harford Ave

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

WILLIAM FORD
CRIMINAL RECORD

11-27-66
11-27-66
11-27-66

BIRTH NO. 66 12907

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 12907

M.E. CASE NO.

| | | | | | |
|--|------------------|---|-------------------------------|---|--|
| 1. NAME OF DECEASED (Type or Print) | | HARRY WILLIAM JOHNSON | | 2. DATE AND HOUR PRONOUNCED DEAD December 22, 1966 1:50 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 Union Memorial Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2525 Guilford Avenue | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 6-24-1929 | 9. AGE (in years last birthday) 37 | If Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Harry A. Johnson | | 14. MOTHER'S MAIDEN NAME Rosie Bradford | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 212-24-8856 | | 17. INFORMANT ADDRESS Mrs. Dorothy Johnson 2525 Guilford Ave. | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Gastro-Intestinal Hemorrhage INTERVAL BETWEEN ONSET AND DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Cirrhosis. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Charles S. Petty</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Petty ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/22/66 | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 12-27-66 | | 23C. NAME of CEMETERY or CREMATORY Mt. Calvary Cemetery | |
| 24A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | 24B. NAME OF REGISTRAR Robert E. Talley | | 24C. FUNERAL DIRECTOR ADDRESS Marshall Jones, Jr. 1735 Harford Ave. | |

WILLIAM B. FORD

WILLIAM B. FORD

1911-1912

William B. Ford
1911-1912

1911-1912

1911-1912

1911-1912

1911-1912

1911-1912

1911-1912

1911-1912

1911-1912

1911-1912

1911-1912

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12908 | |
|---|---------|--|------------------|--|-----------------------------|
| 66 12908 | | | | | |
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| McCLURKIN, EUGENE | | 12/23/66 | | 1:30 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| UNIVERSITY HOSPITAL | | MD | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | BALTIMORE | | | |
| D. STREET ADDRESS (If rural, give location) | | 714 E. 21st STREET | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months Days |
| M | C | MARRIED | 5/30/1907 | 59 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| | | RAILROAD | | Ridgeway, S.C. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| UNKNOWN. | | FANNIE ? | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| YES WW #2 | | | | Estella McClurkin - 714 E. 21st St. | |
| 18. 443X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (A) HCUO DUE TO | | | |
| ANTECEDENT CAUSES | | (B) Arteriosclerosis DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from November 19 65 to November 19 66, that (I) (we) last saw the deceased alive on Nov. 26 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| Jesse T. Holmes | | | | 12/24/66 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Jesse T. Holmes | | 508 E North Ave. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 12/28/66 | | Balto National | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| DEC 27 1966 | | Robert E. Jackson | | MARSHALL W. JONES, JR 1735 HARFORD AVE. | |

University Hospital

MARRIED C M
Galland

W. W. W.

714 E 21st Street
2/20/1917
Ridgeway, S.C.
FARMER
Estate of Wm. W. W. - 21st

Boyle, Maryland
Boyle, Maryland
Boyle, Maryland

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12909 | |
|--|---|---|---|--|---|
| BIRTH NO. 66 12909 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) WILLIAM J. CLOUSER | | 2. DATE AND HOUR OF DEATH 12-19-66 4:25p M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Church Home & Hosp. 35 | | A. STATE Maryland B. COUNTY Balt. Co. | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) P. Randall 53-00 | | | |
| | | D. STREET ADDRESS (If rural, give location) 3701 Old North Point Rd #22 | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) married | 8. DATE OF BIRTH 8-27-91 | 9. AGE (In years last birthday) 75 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10B. KIND OF BUSINESS OR INDUSTRY - | | 11. BIRTHPLACE (State or foreign country) W. VA | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME John Clouser | | | |
| 14. MOTHER'S MAIDEN NAME Sarah McCoy | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | |
| 16. SOCIAL SECURITY NO. - | | 17. INFORMANT Chart ADDRESS | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 199-2-1 | | CAUSE OF DEATH (A) Base. CVA DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) (C) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-19-66 to 12-19-66 and that (I) (we) last saw the deceased alive on 12-19-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE A. E. Subong, Jr. | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-19-66 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. A. E. SUBONG, JR. M.D. | | 23D. ADDRESS Church Home & Hosp. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Removal | 24B. DATE 12/20/66 | 24C. NAME of CEMETERY or CREMATORY Williamsburg | | 24D. LOCATION (City, town, or county) (State) Williamsburg W. Va | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | 25B. NAME OF REGISTRAR Philip Herwig Sons | | 25C. FUNERAL DIRECTOR ADDRESS 2024 Orleans St | | |

Handwritten text, possibly a signature or name, located in the upper right quadrant.

Handwritten text, possibly a signature or name, located in the upper right quadrant.

Handwritten text, possibly a signature or name, located in the center of the page.

Handwritten text, possibly a signature or name, located in the lower left quadrant.

Handwritten text, possibly a signature or name, located at the bottom of the page.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 12910 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12910 | |
|--|----------------------|---|--|--|--|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Meehan, James E. | | | | 2. DATE AND HOUR OF DEATH 12-25-66 01:05 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital | | (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 9-05 | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 1138 Gorsuch Avenue | | | |
| 5. SEX M. | 6. RACE W. | 7. MARRIED NEVER MARRIED WIDOWED , DIVORCED (specify) | | 8. DATE OF BIRTH 01-25-94 | 9. AGE (In years last birthday) 72 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY Toolmaker | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? American | |
| 13. FATHER'S NAME Edward Meehan | | | | 14. MOTHER'S MAIDEN NAME Mary Meade | | | |
| 15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI | | 16. SOCIAL SECURITY NO. 212-05-7656 | | 17. INFORMANT Mary P Meehan | | ADDRESS 1138 Gorsuch Ave | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) OC.V.A. Pneumonia, postoperative | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) Bronchogenic Carcinoma, Rt. | | | |
| 18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II | | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION 12-12-66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fair | | 20A. AUTOPSY? (Yes or No) No. | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-11-66 19 66 to 12-25-66 19 66 , that (I) (we) last saw the deceased alive on 12-25 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Hyong Sok Lee | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 25 Dec. 1966 | |
| 23C. PHYSICIAN NAME (Type) DR HYONG SOK LEE | | | | 23D. ADDRESS THE UNION MEMORIAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE DEC 27 1966 | | 24C. NAME of CEMETERY or CREMATORY Baltimore National | | 24D. LOCATION Baltimore Md | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR Emelville Jenkins | | ADDRESS 2713 Kirk Ave | |

472110

15-22-66

M-211, 11-22-66

Wg.

Baltimore

1138 GORDON AVENUE

01-22-66 15

AMERICAN

Maryland

Mary Wages

O

M W

Retired

Edward Meehan

O.C.V.A.

Psychiatric Department

Brookdale Community College

No

For

15-15-66

15-22-66 15-22-66 15-22-66

15-22-66

Hand 20k Lee

15-22-66

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12911 | |
|---|---------------------|--|------------------------------------|--|--|
| BIRTH NO. 66 12911 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Sprague, Virginia | | 2. DATE AND HOUR OF DEATH December 21st, 1966 7:15 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Howard Co | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Harwood Park | |
| FULL NAME OF HOSPITAL OR INSTITUTION 40 Saint Agnes Hospital Caton & Wilkens Aves. 21229 | | D. STREET ADDRESS (If rural, give location) 1913 Beechfield Ave 21227 | | 63-00 | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 9/15/13 | 9. AGE (In years last birthday) 53 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) West Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME ? Mulligan | | 14. MOTHER'S MAIDEN NAME ? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT ADDRESS Mr. George Sprague same address as above | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Ventricular Fibrillation DUE TO (B) Ischemic myocardial infarction DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from DECEMBER 21 19 66 to DECEMBER 21 1966 , that (I) (we) last saw the deceased alive on DECEMBER 21 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE B. Robert Giangrandi M.D. | | 23B. DATE SIGNED 22 Dec 66 | | 23C. PHYSICIAN'S NAME (Type) B. Robert Giangrandi M.D. | |
| 23D. ADDRESS ST. AGNES HOSPITAL, CATON & WILKENS AV | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/24/1966 | | 24C. NAME OF CEMETERY or CREMATORY Meadowridge Mem. Pk. Cem. | |
| 24D. LOCATION (City, town, or county) (State) Elkridge, Md. | | | | | |
| 25A. DATE RECEIVED BY HEALTH DEPT. DEC 24 1966 | | 25B. NAME OF REGISTRAR Robert E. ... | | 25C. FUNERAL DIRECTOR Wm. J. ... Sons | |
| 25D. ADDRESS Baltimore, Md. | | | | | |

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R-143

66 12912

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 12912

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Ormond B. RIBLET

2. DATE AND HOUR PRONOUNCED DEAD

December 21, 1966 12:00 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 1001 St. Paul Street

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1001 St. Paul Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

Dec. 9, 1909

9. AGE (In years
last birthday)

57

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Interior Designer

10B. KIND OF BUSINESS OR INDUSTRY

The Chambers Company

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Carl Riblet

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

563-03-1591

17. INFORMANT

ADDRESS

Mr. Leo Chambers 1010 North Charles St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Arteriosclerotic Cardiovascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
m. WORK

NOT WHILE
AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/21/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Removal

23B. DATE

12/23/1966

23C. NAME of CEMETERY or CREMATORY

St. Joseph Cemetery

23D. LOCATION

(City, town, or county)

(State)

Wackshaw, Wisconsin

24A. DATE REC'D BY HEALTH DEPT.

DEC 27 1966

24B. NAME OF REGISTRAR

Robert E. Johnson

24C. FUNERAL DIRECTOR

Wm. J. Tibner & Sons

ADDRESS

Baltimore, Md.
North Ave.

WALLACE FORD

200 APR 1962

101 BY 0401

101 BY 0401

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 12913 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 66 12913 | |
|--|------------------|---|--|--|---|--|--|------------------------------|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) SNYDER-RUSSELL H. | | 2. DATE AND HOUR OF DEATH 22 DECEMBER 1966 7 ³⁰ AM | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL | | | | | | A. STATE B. COUNTY MARYLAND | | | |
| (If not in hospital or institution, give street address or location) | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 27-69 | | | |
| D. STREET ADDRESS (If rural, give location) 1508 PENTACRIDGE RD. 21212 | | | | | | | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 08-04-02 | 9. AGE (In years last birthday) 64 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate Offices | | | 10B. KIND OF BUSINESS OR INDUSTRY Mercantile Safe Deposit and Trust | | 11. BIRTHPLACE (State or foreign country) BALTIMORE | | 12. CITIZEN OF WHAT COUNTRY? AMERICAN | | |
| 13. FATHER'S NAME George Edwin Snyder | | | | 14. MOTHER'S MAIDEN NAME Minnie Bell Jamison | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 220-05-2900 | | 17. INFORMANT ADDRESS Mr. James R. Snyder Springfield, Pa. 19064 552 W. Rolling Rd. | | | | |
| 18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | CAUSE OF DEATH (A) DUE TO Coronary vascular accident (Clinical diagnosis) (B) DUE TO (C) DUE TO Pathologic diagnosis pending further studies | | | INTERVAL BETWEEN ONSET AND DEATH None |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-11-1966 to 12-22-1966, that (I) (we) last saw the deceased alive on 12-22-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Fridtjofur Bjornsson M.D. | | | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 12-22-66 | |
| 23C. PHYSICIAN'S NAME (Type) FRIDTJOFUR BJORNSSON | | | | | | 23D. ADDRESS UNION MEMORIAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/22/1966 | | 24C. NAME of CEMETERY or CREMATORY Lorraine Park Cemetery | | 24D. LOCATION (City, town, or county) (State) Woodlawn, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | 25B. NAME OF REGISTRAR Robert E. Johnson | | 25C. FUNERAL DIRECTOR Wm. J. Tichner & Sons North & South, Md. | | | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 12914 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 12:23:CG | | 66 12914 | |
|---|--|-----------------------------|--|--|--|--|--|--|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE | | B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland Gen Hosp | | | | (If not in hospital or institution, give street address or location) | | Md | | Baltimore | |
| 5. SEX m | | | | 6. RACE w | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | | 8. DATE OF BIRTH 3/31/08 | |
| 9. AGE (In years last birthday) 58 | | | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clergyman | | 11. BIRTHPLACE (State or foreign country) Va | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME David Cluff | | | | 14. MOTHER'S MAIDEN NAME Lena Wirt | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 3 | | | |
| 16. SOCIAL SECURITY NO. 218-12-8038 | | | | 17. INFORMANT Chart | | | | ADDRESS | |
| 18. 457X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) ruptured abdominal aorta due to thoracic abdominal aneurysm (B) _____ DUE TO (C) _____ | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 2 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/23 1966 to 12/23 1966, that (I) (we) last saw the deceased alive on 12/23 1966 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Daniel C. Willkerson | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/23/66 | |
| 23C. PHYSICIAN'S NAME (Type) Daniel C. Willkerson | | | | | | 23D. ADDRESS 421 Regester Ave | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/27/1966 | | 24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | | | 25B. NAME OF REGISTRAR Wm. J. Tinkner | | 25C. FUNERAL DIRECTOR Wm. J. Tinkner & Son | | | |
| 25D. ADDRESS Baltimore, Md | | | | 25E. ADDRESS Baltimore, Md | | | | | |

Chart

Chart

18/10/1918

18/10/1918

FUNERAL DIRECTOR: IMPORTANT

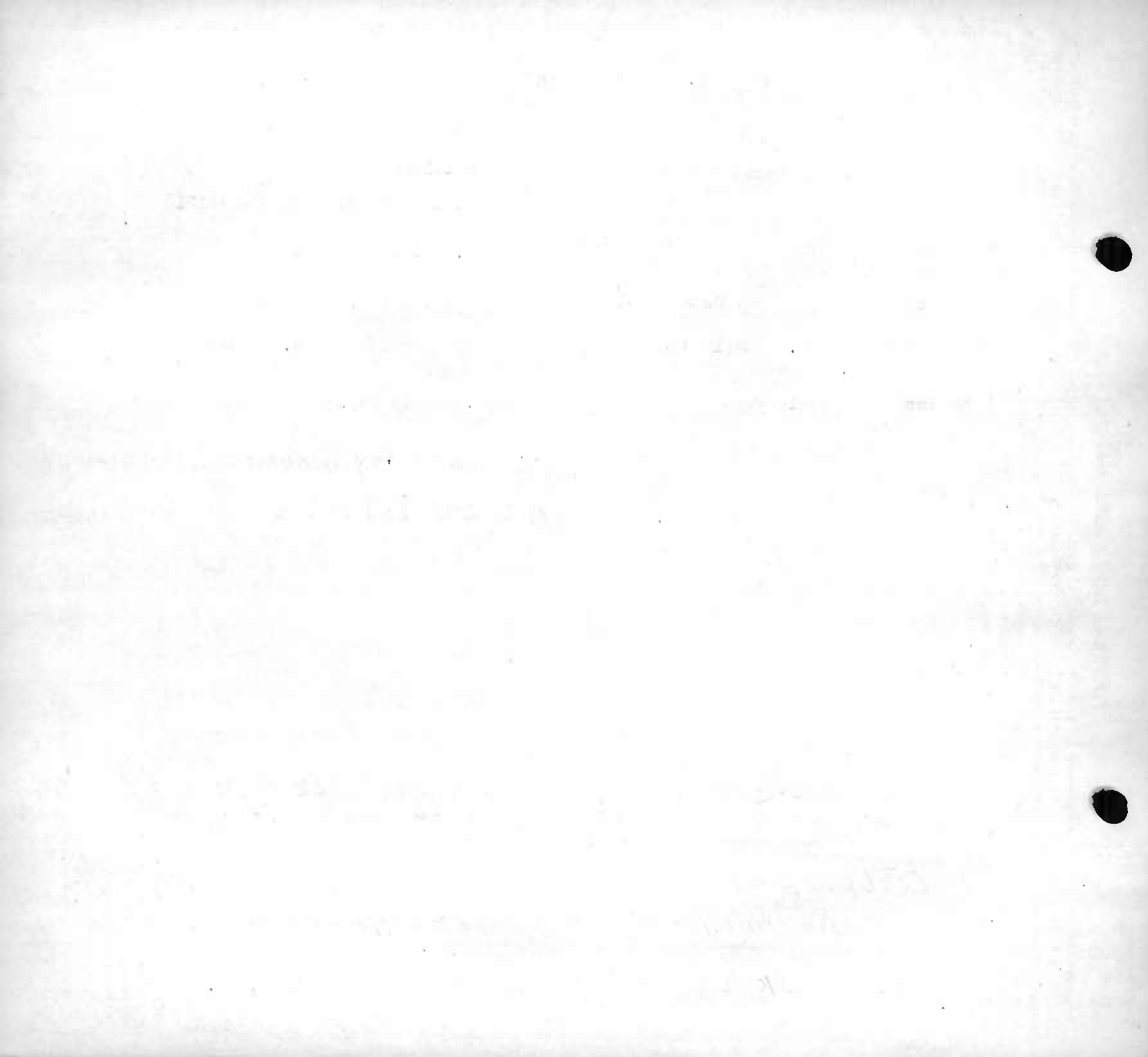
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 12915 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12915 | |
|--|------------------|--|--|--|--|--|------------------------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Sadie Elizabeth Richardson | | | | 2. DATE AND HOUR OF DEATH December 22, 1966 3P M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Wesley Home, Inc. 2211 W. Rogers Avenue Baltimore, Maryland 21209 | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 27-15 D. STREET ADDRESS (If rural, give location) 2211 W. Rogers Ave. 21209 | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH Oct. 7, 1881 | 9. AGE (In years lost birthday) 81 | 10. Under 1 Yr. Months: Days: | 11. Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never Worked | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME Harry Dushane Richardson | | | 14. MOTHER'S MAIDEN NAME Victoria Jackins | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS The Wesley Home, Inc. 2211 W. Rogers Ave. | | |
| 18. I 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Anteriosplenic cardio-vascular disease DUE TO | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from May 9 1961 to December 22 1966, that (I) (we) lost saw the deceased alive on December 21 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE John W. Barnaby | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 23 Dec 66 | |
| 23C. PHYSICIAN'S NAME (Type) JOHN W. BARNABY | | | | 23D. ADDRESS M.D. 1531 E North Ave | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/24/1966 | | 24C. NAME of CEMETERY or CREMATORY Druid Ridge Cemetery | | 24D. LOCATION (City, town, or county) (State) Pikesville, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | 25B. NAME OF REGISTRAR Wm J. Tichner & Sons | | 25C. FUNERAL DIRECTOR Wm J. Tichner & Sons | | ADDRESS Baltimore, Md. | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12916 | |
|--|-------------------------|--|--|--|---|
| BIRTH NO. 66 12916 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) George I. Eagleston | | | 2. DATE AND HOUR OF DEATH December 21, 1966 2:25 p. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 Johns Hopkins Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 9-02 D. STREET ADDRESS (If rural, give location) 1513 Upshire Road 21218 | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH Oct. 10, 1895 | 9. AGE (In years lost birthday) 71 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk | | 10B. KIND OF BUSINESS OR INDUSTRY Beth Steel | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 13. FATHER'S NAME George I. Eagleston | | | 14. MOTHER'S MAIDEN NAME Catherine M. Carr | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Mrs. Jennie Eagleston same address | |
| 18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CORONARY THROMBOSIS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. A.S.C.V DISEASE HYPERTENSION 10 YEARS + | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) GOUT | | |
| MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. GOUT | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from JAN. 26, 1962 to DEC. 21, 1966 , that (I) (we) last saw the deceased alive on NOV. 12, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (do) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Arthur Karfgin M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED 12/23/66 | |
| 23C. PHYSICIAN'S NAME (Type) ARTHUR KARFGIN M.D. | | | | 23D. ADDRESS 1532 HAVENWOOD ROAD | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/24/1966 | | 24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Pikesville, Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | 25B. NAME OF REGISTRAR Wm. J. Tipton | | 25C. FUNERAL DIRECTOR Wm. J. Tipton & Sons North Pa. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|--|--------------------------------|---|--|--|---|
| BIRTH NO. 66 12917 | | CERTIFICATE OF DEATH | | 86 12917 | |
| M.E. CASE NO. 1 | | | 2. DATE AND HOUR OF DEATH 12/22/66 12 34 A.M. | | |
| 1. NAME OF DECEASED (Type or Print) Smith, Ella Triplett | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 Sinai Hospital of Baltimore | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 27-18 | | |
| | | | D. STREET ADDRESS (If rural, give location) 5328 Nelson Ave. 21215 | | |
| 5. SEX Fe | 6. RACE Cauc. | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 7/20/24 | 9. AGE (In years lost birthday) 42 | If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Baltimore | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Charles Triplett | | | 14. MOTHER'S MAIDEN NAME Kane | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | 17. INFORMANT ADDRESS Mr. Charles F. Smith same address as above | | |
| 18. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oslhenio, etc. It means the disease, injury or complication which caused death.) Tracheal obstruction DUE TO (A) 2 days ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Bronchogenic Carcinoma 6 weeks DUE TO (B) 6 weeks (C) | | | INTERVAL BETWEEN ONSET AND DEATH 2 days | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 12/19/66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of Lung Bronchoscopy | | 20A. AUTOPSY (Yes or No) (No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this) hospital attended the deceased from 12/19 19 66 to 12/22 19 66 , that (I) (we) last saw the deceased alive on 12/22 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Erwin H. Hesselberg M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED 12/22/66 | |
| 23C. PHYSICIAN'S NAME (Type) Erwin H. Hesselberg | | 23D. ADDRESS Sinai Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 12/24/1966 | 24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cemetery | | 24D. LOCATION (City, town, or county) (State) Woodlawn, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | 25B. NAME OF REGISTRAR Wm. J. Tackman | | 25C. FUNERAL DIRECTOR ADDRESS Wm. J. Tackman & Sons Baltimore, Md. | |



66 12918

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 12918

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

DUDLEY P.

SHEATS

2. DATE AND HOUR PRONOUNCED DEAD

December 20, 1966

2:25 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

37 Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

48 Market Place

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)
Divorced

8. DATE OF BIRTH

Mar. 25, 1919

9. AGE (In years
last birthday)

47

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Parts - Clerk

10B. KIND OF BUSINESS OR INDUSTRY

Automobile

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Everett

14. MOTHER'S MAIDEN NAME

Anna Ivens

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

World War II

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Alinda M. Sparks 3611 Fieldstone Rd.

18. 422.1 + 1322.0
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, osthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

Arteriosclerotic Cardiovascular Disease

(A) DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Acute Ethylism

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breiteneker, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/21/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial - -

23B. DATE

12/23/1966

23C. NAME of CEMETERY or CREMATORY

Baltimore National Cemetery Baltimore, Md.

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

VALLEY FORGE

EXHIBIT

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | Registered No. 66 12919 | |
|---|--|--|---|--|--|
| BIRTH NO. 66 12919 | | M.E. CASE NO. | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) FRANK LIBERTO | | | 2. DATE AND HOUR OF DEATH 12-21-66 4:45 P M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | A. STATE B. COUNTY | | |
| 33 THE JOHNS HOPKINS HOSPITAL | | | MARYLAND | | |
| 5. SEX MALE | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | |
| 6. RACE WHITE | | | BALTIMORE | | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | | | D. STREET ADDRESS (If rural, give location) | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STOREKEEPER | | | 3440 CHESTNUT AVENUE | | |
| 10B. KIND OF BUSINESS OR INDUSTRY STATE | | | 8. DATE OF BIRTH 10-19-05 | | |
| 13. FATHER'S NAME FRANK LIBERTO | | | 9. AGE (in years lost birthday) 61 | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 11. BIRTHPLACE (State or foreign country) MD | | |
| 16. SOCIAL SECURITY NO. 220-14-8802 | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 17. INFORMANT FRANCIS LIBERTO (SAME) | | | 14. MOTHER'S MAIDEN NAME CARMELIA | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 053.4 I | | | Sepsis. | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work Not While At Work | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/12/66 to 12/21/66 that (I) (we) lost saw the deceased alive on 12/21/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE W. Wilson | | | 23B. DATE SIGNED 12/21/66 | | |
| 23C. PHYSICIAN'S NAME (Type) W. Stan Wilson | | | 23D. ADDRESS JWH | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12/24/66 | | 24C. NAME OF CEMETERY or CREMATORY MT. OLIVET | |
| 24D. LOCATION (City, town, or county) BALTO. MD. | | 24E. LOCATION (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR Paul E. Cloninger | |
| 25D. ADDRESS | | 25E. ADDRESS | | 25F. ADDRESS | |

STATE

THE CHIEF OF POLICE

IN

STATE

STOCKHOLM

THE

STOCKHOLM

YES

STOCKHOLM

STOCKHOLM

S-363
C-462

66 12920

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 12920

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Rena Quincanna Stewart (Clark)

2. DATE AND HOUR PRONOUNCED DEAD

12/25/66 10:10 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

44

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

631 Willow Ave.

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Aug. 24, 1941

9. AGE (In years
last birthday)

25

10. Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

House Wife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto., Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Quincy Clark

14. MOTHER'S MAIDEN NAME

Annie B. McGowens

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

216-40-1922

17. INFORMANT

ADDRESS

Mrs. Annie Clark 3814 Old Frederick

18. E981X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Gunshot wound of head
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

home

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

631 Willow Ave.

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)
12 25 66 9:45a.m.

21E. INJURY OCCURRED

WHILE AT
WORK

NOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

shot by husband

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D. ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/26/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/29/66

23C. NAME of CEMETERY or CREMATORY

Mt Calvary Cemetery

23D. LOCATION

(City, town, or county)

(State)

Ann Arundel Cty., Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Wm C March 928 E. North Ave.

DEC 27 1966

N 856.4

WALLACE
FOUR
PAPER
CONTAIN

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------------------|--|------------------------------------|---|---|
| BIRTH NO. 66 12921 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12921 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) CHARLES Cox | | 2. DATE AND HOUR OF DEATH 12/23/66 9:57 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 15-11 | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI Hosp. of Balt., Inc. | | D. STREET ADDRESS (If rural, give location) 3711 Belle Ave. | | | |
| 5. SEX M | 6. RACE N | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M | 8. DATE OF BIRTH 3/25/82 | 9. AGE (In years last birt) 84 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABOR | | 10B. KIND OF BUSINESS OR INDUSTRY RAILROAD | | 11. BIRTHPLACE (State or foreign country) Md. | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME FRANK Cox | | 14. MOTHER'S MAIDEN NAME MIRANDA HARD | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT DAUGHTER | |
| ADDRESS SAME | | 18. 593X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oslhenia, etc. I) means the disease, injury or complication which caused death.) CAUSE OF DEATH Renal Azotemia 2° to Renal Dis. of UNKNOWN ETIOLOGY | | INTERVAL BETWEEN ONSET AND DEATH UNKNOWN | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. PNEUMONIA | | | | 1 week | |
| 19A. DATE OF OPERATION None | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (nately medical examiner) None | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (s) (this hospital) attended the deceased from 12/19 1966 to 12/23 1966 , that (s) (we) lost saw the deceased alive on 12/23 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE J. Brett Lazar | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/23/66 | |
| 23C. PHYSICIAN'S NAME (Type) J. BRETT LAZAR | | 23D. ADDRESS M.D. SINAI Hosp. of Balt., Inc. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/27/66 | | 24C. NAME of CEMETERY or CREMATORY Arbutus Mem. PK Arbutus, Md. | |
| 24D. LOCATION (City, town, or county) (State) Arbutus, Md. | | 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR George H. Kilar 1548 N. Galloway St. | |
| 25C. FUNERAL DIRECTOR | | ADDRESS | | | |

48 11/24/12

Rec'd of the 11th Nov 1912
11/24/12

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12922 | |
|--|------------------|---|-----------------------------|---|--|
| BIRTH NO. 66 12922 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) ROSA E. HUBBARD | | 2. DATE AND HOUR OF DEATH 12-25-66 6 00 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224 | | A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, with RURAL and give township) BALTIMORE 26-01 D. STREET ADDRESS (If rural, give location) 1850 W. MULBERRY STREET - 21223 | | | |
| 5. SEX FEMALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 8/31/15 | 9. AGE (In years lost birthday) 51 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) VIRGINIA | |
| 13. FATHER'S NAME EDWARD LEE | | 14. MOTHER'S MAIDEN NAME MARIE CANADA | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 212-32-3810 | | 17. INFORMANT RECORDS: BCH, 4940 Eastern Ave., Balto. Md. 21224 | |
| 18. 153.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | CAUSE OF DEATH (A) ADENOCARCINOMA COLON DUE TO (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 13 MONTHS | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 26 NOVEMBER, 1966 to 25 DECEMBER, 1966, that (I) (we) last saw the deceased alive on 25 DECEMBER, 1966 and that in (my) (our) opinion death occurred on the date and hour end from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Daniel D. Foote M.D. | | | | 23B. DATE SIGNED 12-25-66 | |
| 23C. PHYSICIAN'S NAME (Type) DANIEL D. FOOTE M.D. | | | | 23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 Eastern Avenue, Baltimore, Md. 21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-26-66 | | 24C. NAME OF CEMETERY or CREMATORY Church Cemetery | |
| 24D. LOCATION Lynchburg, Virginia | | 24E. LOCATION (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | 25B. NAME OF REGISTRAR George E. Kelton | | 25C. FUNERAL DIRECTOR George Kelson 1348 N. Calhoun St. | |

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12923

BIRTH NO. 66 12923

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

FREDERICK QUEEN

2. DATE AND HOUR PRONOUNCED DEAD

December 22, 1966 11:25 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

39 Provident Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4017 Colborne Road

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

8-18-33

9. AGE (in years
last birthday)

33

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Frederick Queen

14. MOTHER'S MAIDEN NAME

Elizabeth Amby

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Elizabeth Queen 4017 Colborne Rd.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)Left empyema and peritonitis
complicating stabwound of trunk

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B).....
DUE TO

(C).....

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

unknown

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

unknown

21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

12-4-66

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Stabbed by unknown assailant

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S Charles S. Springate, M.D.
NAME (Type)CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

December 23, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12-28-66

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

DEC 27 1966

24B. NAME OF REGISTRAR

Charles S. Springate

24C. FUNERAL DIRECTOR

ADDRESS

George G. Kelson 1348 N. Calhoun St.

VALLEY PAPER

WATERMARK BOARD

USE AND CONTROL

1911

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--------------|--|-----------------------------|--|--|
| BIRTH NO. 66 12924 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12924 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) John Edward French | | 2. DATE AND HOUR OF DEATH Dec. 26, 1966 12:20 a.m. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | D. STREET ADDRESS (If rural, give location) | |
| 38 University Hospital | | Maryland Baltimore | | 20-06 3 N. Bernice Ave | |
| 5. SEX M | 6. RACE N | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married | 8. DATE OF BIRTH 10/1/16 | 9. AGE (In years lost birthday) 50 | 10. If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Virginia | |
| 13. FATHER'S NAME John C. French | | 14. MOTHER'S MAIDEN NAME Estelle Bulford | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Yvonne French | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 422.241581.1 | | CAUSE OF DEATH (A) DUE TO Myocardiodiopathy | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| (C) DUE TO | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Laennec's cirrhosis | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify Medical Examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec. 22 19 66 to Dec 26 19 66, that (I) (we) last saw the deceased alive on Dec 25 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE A. M. Morris | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/26/66 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS University Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-29-66 | | 24C. NAME of CEMETERY or CREMATORY Baltimore Nat'l. Cem. | |
| 24D. LOCATION Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | | |
| 25B. NAME OF REGISTRAR George G. Kelson | | 25C. FUNERAL DIRECTOR ADDRESS 1348 N. Calhoun St. | | | |

M N married University Hospital

John C. French

Myocardial
James French
Estelle Bulfinch
Virginia
10/11/20
3 N. Bernice Ave.
Baltimore
Maryland

Jacques's children

yes

A. M. Mann

University Hospital

12/10/20

Dec 27 Dec 27 Dec 27

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|------------------|---|------------------------------|--|---|
| BIRTH NO. 66 12925 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12925 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) COONEY, JULIA | | 2. DATE AND HOUR OF DEATH 22ND DECEMBER 1966 9:00A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE B. COUNTY MARYLAND Balto. Co. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-20 | |
| FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL CATON & WILKENS AVES. 21229 | | D. STREET ADDRESS (If rural, give location) 22 DUNGARRIE RD. 21228 | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 4/5/1919 | 9. AGE (In years last birthday) 47 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | 12. CITIZEN OF WHAT COUNTRY? US |
| 13. FATHER'S NAME NATHANIEL WHITE | | 14. MOTHER'S MAIDEN NAME MARY L. DAVIS | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT CARL J. COONEY | | ADDRESS 22 DUNGARRIE RD. 28 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 464X1 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Massive Pulmonary Embolism (B) Thrombophlebitis (C) CHIEF OR ASST. MEDICAL EXAMINER CERTIFICATION APPROVED BY 12/23/66 | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Sally E. Davis | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/22/66 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/26/66 | | 24C. NAME OF CEMETERY or CREMATORY Loudon PK. Cem. | |
| 24D. LOCATION (City, town, or county) (State) BALTIMORE Md | | 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | 25B. NAME OF REGISTRAR C. S. Mac Nab | |
| 25C. FUNERAL DIRECTOR C. S. Mac Nab | | 25D. ADDRESS BALTO 28 MD | | | |

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| 3226 66 12926 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12926 | |
|---|---------|---|------------------|--|--|
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | JOHN T. FITZER DEC 23, 1966 4:55 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | MARYLAND BALTIMORE 19-04 | |
| 31 BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224 | | D. STREET ADDRESS (If rural, give location) | | 324 S. MOUNT ST 21223 | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | If Under 1 Yr. Months Days Hours Min. |
| MALE | White | Single | 10/5/89 | 77 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Water Meter Reader | | CITY GOV'T. | | MARYLAND | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| GEORGE T. FITZER | | MARY E. KLEES | | U. S. A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO NONE | | 219-10-8911 | | RECORDS: BCH 4940 Eastern Avenue 21224 | |
| 18. 154 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO Rarconoma of the Rectum (B) DUE TO Gastro Colic Fistula (C) _____ | | 3 years | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Atherosclerosis, Left Hemiparesis | | 6 weeks | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/9/1966 to 12/23/1966, that (I) (we) last saw the deceased alive on 12/23/1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | 23A. SIGNATURE Alan J. Barnes M.D. | | 23B. DATE SIGNED 12/23/1966 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | 23E. FUNERAL DIRECTOR | |
| Dr. Alan J. Barnes | | 4940 Eastern Avenue Baltimore, Maryland 21224 | | Schwab Funeral Home | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| BURIAL | | 12-27-66 | | NEW CATHEDRAL | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| DEC 27 1966 | | J. E. Entel | | Schwab Funeral Home | |
| 25D. LOCATION (City, town, or county) (State) | | 25E. ADDRESS | | 25F. ADDRESS | |
| BALTIMORE, MD | | BALTIMORE, MD | | 2101 Frederick Ave. | |

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FUNERAL DIRECTOR: IMPORTANT

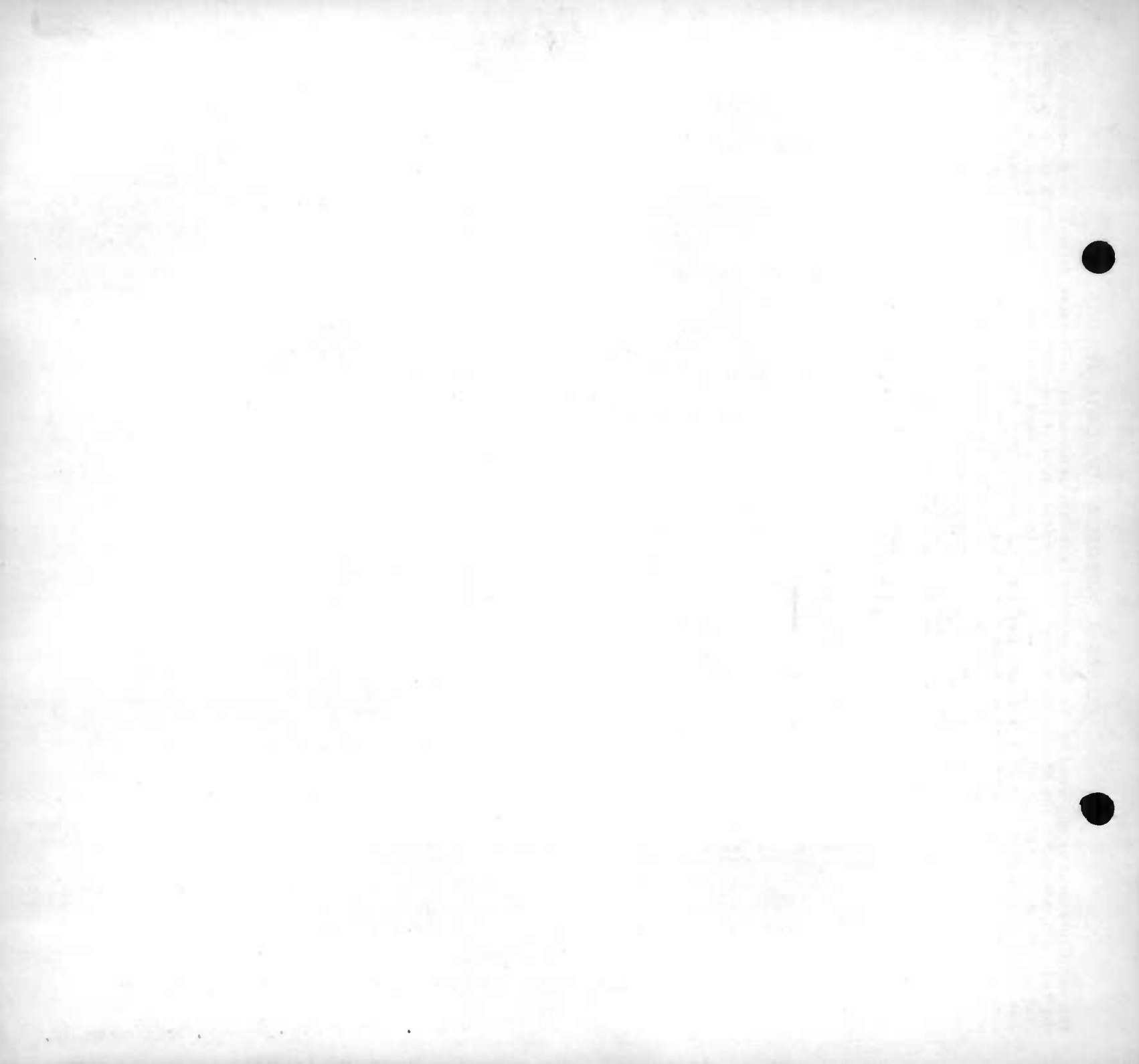
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|--|--|---|--|
| BIRTH NO. 66 12927 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12927 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED McDonald | | 2. DATE AND HOUR OF DEATH DEC. 25, 1966 3:15 P. M. | |
| 1. NAME OF DECEASED (Type or Print) MARY McDonald | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| <p>CERTIFICATE AMENDED</p> <p>12-28-66</p> <p>100 N. ATHOL AVE</p> | | <p>5. CITY OR TOWN (If outside city limits, write RURAL and give township)</p> <p>BALTIMORE</p> | | <p>6. COUNTY</p> <p>MARYLAND</p> | |
| 5. SEX FEMALE | | 6. RACE WHITE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE | |
| 8. DATE OF BIRTH DEC. 6, 1887 | | 9. AGE (In years last birthday) 79 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMSTRESS | |
| 11. BIRTHPLACE (State or foreign country) PENNSYLVANIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME JAMES L. McDonald | |
| 14. MOTHER'S MAIDEN NAME MARY J. MacDonald | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO NONE | | 16. SOCIAL SECURITY NO. 287-03-8918 | |
| 17. INFORMANT YERONICA TORNEY | | 18. CAUSE OF DEATH | | ADDRESS 107 K. ROCK GLEN RD. | |
| 18. I 175.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) METASTATIC CA OF OVARY | | INTERVAL BETWEEN ONSET AND DEATH 5-6 MONTHS | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION SEPT '66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED INTESTINAL OBSTRUCTION | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from AUGUST 19 66 to SEPT. 19 66, that (I) (we) last saw the deceased alive on SEPTEMBER 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE W. K. GALLAGER, JR. | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 25 Dec 66 | |
| 23C. PHYSICIAN'S NAME (Type) W. K. GALLAGER, JR. | | 23D. ADDRESS 6630 BALT. NAT. PIKE, BALT 21228 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12-28-66 | | 24C. NAME OF CEMETERY or CREMATORY NEW CATHEDRAL | |
| 24D. LOCATION BALTIMORE, MD | | 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | 25B. NAME OF REGISTRAR | |
| 25C. FUNERAL DIRECTOR ADDRESS | | 25D. NAME OF REGISTRAR | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12928 | |
|---|---------------------|--|-------------------------------------|--|--|
| BIRTH NO. 66 12928 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>JAMES. Philip McDonough.</i> | | 2. DATE AND HOUR OF DEATH <i>Dec 24/66 11:10 P.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hospital</i> | | A. STATE <i>Maryland</i> B. COUNTY <i>27-10</i> | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 12</i> | | | |
| <i>38</i> | | D. STREET ADDRESS (If rural, give location) <i>4223 Ivanhoe Ave.</i> | | | |
| 5. SEX <i>M</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Single</i> | 8. DATE OF BIRTH <i>May 1/29</i> | 9. AGE (In years last birthday) <i>37</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Ind.</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i> | | 13. FATHER'S NAME <i>John P McDonough</i> | | | |
| 14. MOTHER'S MAIDEN NAME <i>Marie Krempell. dec.</i> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | | |
| 16. SOCIAL SECURITY NO. <i>None</i> | | 17. INFORMANT ADDRESS <i>admission sheet.</i> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>054 Y1</i> | | CAUSE OF DEATH (A) <i>Septic Shock</i> DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>NO</i> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Dec 21 1966</i> to <i>Dec 24 1966</i> , that (I) (we) last saw the deceased alive on <i>Dec 24 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Rodrigo Toro</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>Dec 24/66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Rodrigo Toro</i> | | 23D. ADDRESS <i>University Hospital</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12/28/1966</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Holy Redeemer Cemetery</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 27 1966</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Taylor</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>John A. Moran Inc. 3000 E. Baltimore St.</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|---|--------------------------------|---|--------------------------------------|---|---|
| BIRTH NO. 66 12929 | | CERTIFICATE OF DEATH | | 66 12929 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Richard C. Miller</i> | | 2. DATE AND HOUR OF DEATH <i>December 22, 1966 11:00 P.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <i>90 Gould Convalesarium 6716 Belair Road</i> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>34 N. Luzerne Ave</i> | | | |
| 5. SEX <i>Male</i> | 6. RACE <i>White</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i> | 8. DATE OF BIRTH <i>4/27/1888</i> | 9. AGE (In years last birthday) <i>78</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Supervisor of Election</i> | | 11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 13. FATHER'S NAME <i>Charles Miller</i> | | 14. MOTHER'S MAIDEN NAME <i>Mary Praley</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>275-70-3074</i> | | 17. INFORMANT <i>Mr. William Miller Box 276A, Rte 1</i> | |
| 18. <i>490 X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH <i>Pasadena, Maryland</i> <i>Acute Lobr Pneumonia</i> (A) DUE TO (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH <i>8 days</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | <i>Chronic Brain Syndrome</i> | | <i>6 mos</i> | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from <i>Dec 8</i> 19 <i>66</i> to <i>Dec 22</i> 19 <i>66</i> , that (1) (we) last saw the deceased alive on <i>Dec 16</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Albert B. Bradley</i> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>12/23/66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Albert B. Bradley</i> | | 23D. ADDRESS <i>4900 Belair Road</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | 24B. DATE <i>12/24/1966</i> | 24C. NAME of CEMETERY or CREMATORY <i>Loudon Park Cemetery</i> | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR <i>John A. Morari Inc. 3000 E. Baltimore St.</i> | |

11-20-4

Copy

Dear Mr. Brown

Dear

Mr. Brown

11-20-4

Dear Mr. Brown

11/20/4

Mr. Brown

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | Registered No. 30-35-04 | |
|--|---------------|---|--|--|--|
| BIRTH NO. 66 12930 | | CERTIFICATE OF DEATH | | 66 12930 | |
| M.E. CASE NO. 36-35-04 | | 1. NAME OF DECEASED (Type or Print) BUCHANAN, FREDERICK | | 2. DATE AND HOUR OF DEATH 12/21/66 800 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND University Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | |
| FULL NAME OF HOSPITAL OR INSTITUTION 38 BALTIMORE MARYLAND | | D. STREET ADDRESS (If rural, give location) 1610 Appleton St. | | 15-02 | |
| 5. SEX MALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED | 8. DATE OF BIRTH 8/15/197 | 9. AGE (In years last birthday) 69 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired | | 10B. KIND OF BUSINESS OR INDUSTRY unknown | 11. BIRTHPLACE (State or foreign country) South Carolina | 12. CITIZEN OF WHAT COUNTRY? U.S.A | |
| 13. FATHER'S NAME Joe Buchanan | | 14. MOTHER'S MAIDEN NAME LELA- (?) | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unknown | |
| 16. SOCIAL SECURITY NO. — | | 17. INFORMANT Admission record | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH (A) DUE TO Pulmonary insufficiency atelectasis & emphysema (B) DUE TO Squamous cell carcinoma of anus (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 5 days | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Lympho Pathium Venereum | | | |
| 19A. DATE OF OPERATION 12/13/66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Lympho Pathium Venereum | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) None | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None | | 21C. WHERE DID INJURY OCCUR? None | |
| 21D. TIME OF INJURY (APPROX.) None | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? None | |
| 22. I certify that (I) (this hospital) attended the deceased from 11/27 1966 to 12/21 1966, that (I) (we) lost saw the deceased alive on 12/21 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | 23A. SIGNATURE Fred R. Eilben M.D. | | 23B. DATE SIGNED 12/21/66 | |
| 23C. PHYSICIAN'S NAME (Type) Fred R. Eilben M.D. | | 23D. ADDRESS University Hospital | | | |
| 24A. BURIAL CREMATION REMOVAL (Specify) Burial | | 24B. DATE 12/24/66 | | 24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Ph. Baltimore | |
| 24D. LOCATION (City, town, or county) Baltimore | | 24E. STATE md | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| 25D. ADDRESS | | 25E. ADDRESS | | 25F. ADDRESS | |

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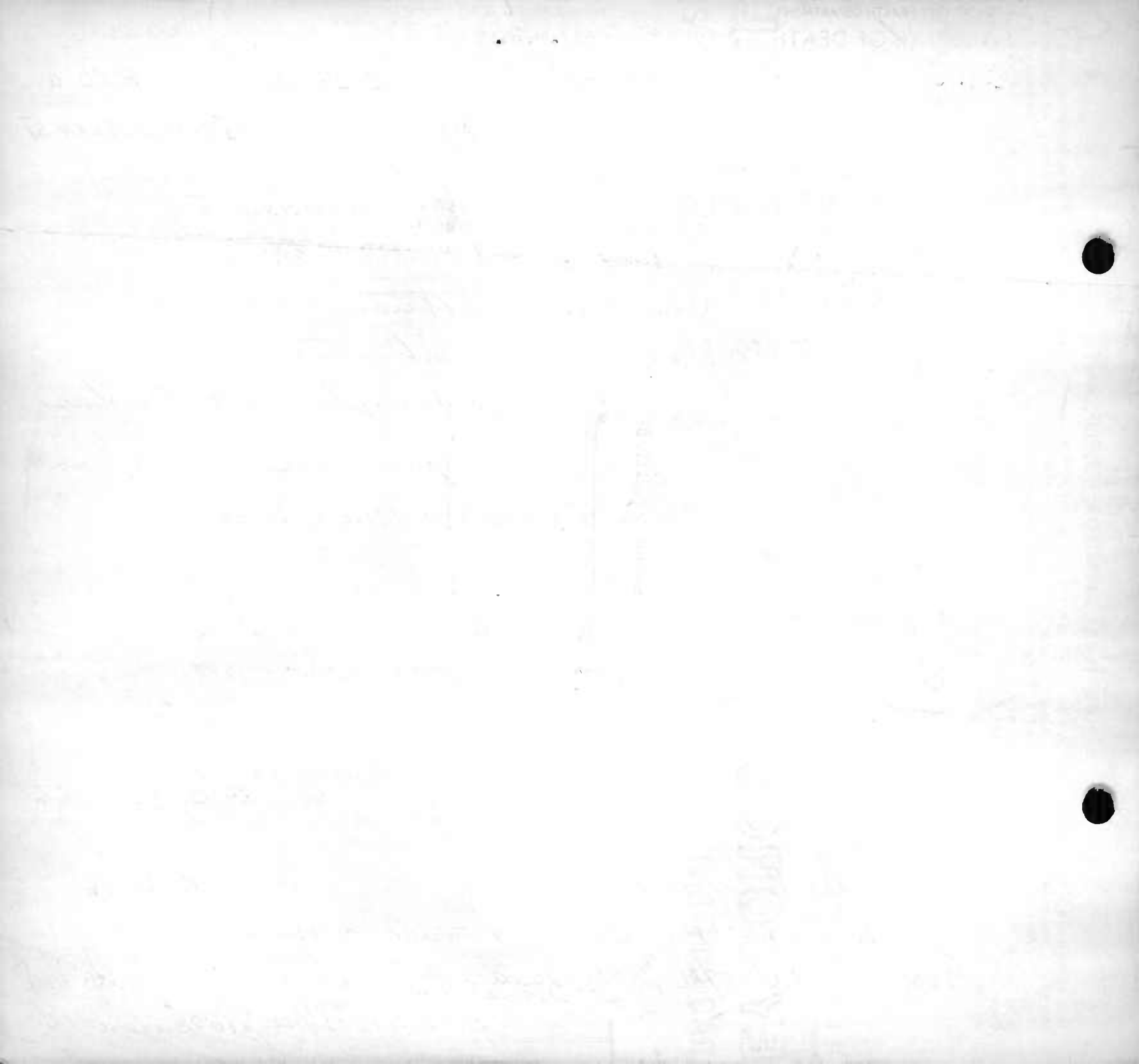
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

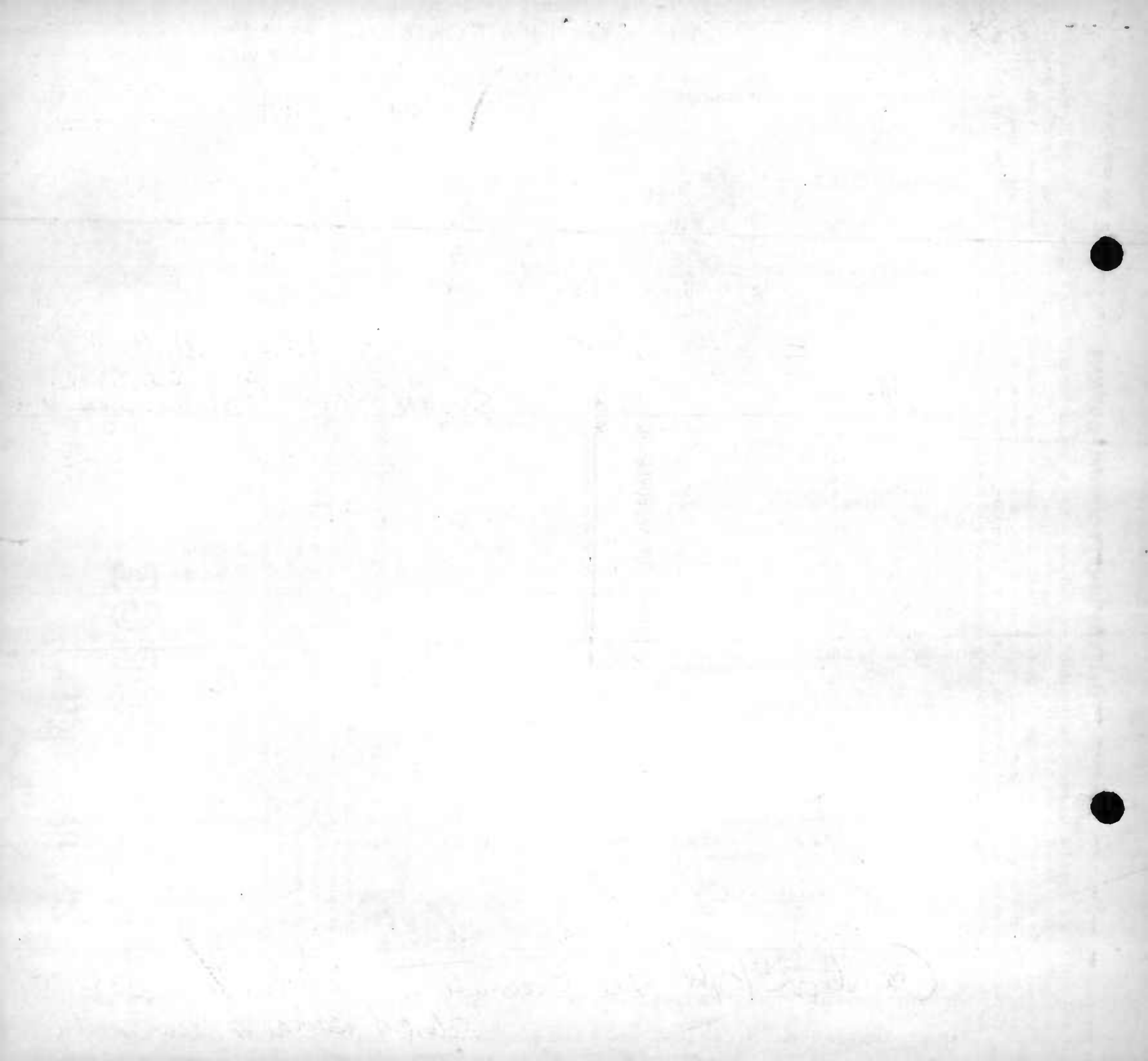
| BIRTH NO. 66 12931 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12931 | |
|--|---------------------|--|--|---|--|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) CAPLAN, HYMAN | | | | 2. DATE AND HOUR OF DEATH 12.24.66 | | 6.20 a.m. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL OF MARYLAND | | (If not in hospital or institution, give street address or location) | | A. STATE MD | | B. COUNTY 1500 PRESSTMAN ST | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 15-01 | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 1500 PRESSTMAN ST-1500 | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | | 8. DATE OF BIRTH 2.14.1877 | 9. AGE (In years lost birthday) 89 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clothier | | 10B. KIND OF BUSINESS OR INDUSTRY Clothing | | 11. BIRTHPLACE (State or foreign country) Lithuania | | 12. CITIZEN OF WHAT COUNTRY? Lithuanian | |
| 13. FATHER'S NAME Jacob Caplan | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Jacob Caplan 1500 Presstman St | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) BRONCHOPNEUMONIA | | | | CAUSE OF DEATH (A) DUE TO BRONCHOPNEUMONIA (B) DUE TO COMPRESSIVE FRACTURE L1, L3 (C) | | INTERVAL BETWEEN ONSET AND DEATH 48 hours | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II | | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Carcinoma of the prostate. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1400 PRESSTMAN ST 15-01 | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 12 11 1966 | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? Fell down on the floor | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12.11.1966 to 12.24.1966 that (I) (we) last saw the deceased alive on 12.24.1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Milos Radojnovic | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12.24.66 | |
| 23C. PHYSICIAN'S NAME (Type) MILOS RADOJKOVIC | | | | 23D. ADDRESS M.D. LUTHERAN HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 12/25/66 | | 24C. NAME OF CEMETERY or CREMATORY Beth Isaac Adath Shalom | | 24D. LOCATION (City, town, or county) (State) German Hill Balto Md | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR Geek Firms, Inc. 2100 Eutan Pl. | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|---|---|--|--|
| BIRTH NO. 66 12932 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12932 | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type as Print) MR. JOHN EDWARD WHITE JR | | | | | |
| 2. DATE AND HOUR OF DEATH 7:50am 12/23/66 M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | A. STATE MD B. COUNTY H.A. Co. | | |
| MARYLAND GENERAL HOSPITAL 48 | | | 2 LUNA LANE - SEVERNA PARK MD | | |
| 5. SEX MALE | | | 6. RACE WHITE | | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED | | | 8. DATE OF BIRTH 03/20/02 | | |
| 9. AGE (In years last birthday) 64 | | | 10. CITIZEN OF WHAT COUNTRY? UNITED STATES | | |
| 11. BIRTHPLACE (State or foreign country) STATE - MARYLAND | | | 12. CITIZEN OF WHAT COUNTRY? UNITED STATES | | |
| 13. FATHER'S NAME JOHN W. WHITE, Sr. | | | 14. MOTHER'S MAIDEN NAME MARY Wilson | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 01-4788 | | |
| 17. INFORMANT SUSAN Lane - Cambridge, Md | | | ADDRESS 405 Washington St | | |
| 18. CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | |
| CHRONIC PULMONARY EMPHYSEMA SEVERE | | | | | |
| ANTECEDENT CAUSES | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| CLAV & RIB TRAUMA | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) SEVERNA PARK MD | |
| 21D. TIME OF INJURY (APPROX.) 12 21 66 | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? EPISODE OF SYNCOPE | |
| 22. I certify that (this hospital) attended the deceased from 12-21-1966 to 12-23-1966, that (I) (we) last saw the deceased alive on 12-23-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE GARY LEE NOBEL M.D. | | | | 23B. DATE SIGNED 12-23-66 | |
| 23C. PHYSICIAN'S NAME (Type) GARY LEE NOBEL M.D. | | | | 23D. ADDRESS 2309-A Anclona Ct Balto Mo. | |
| 24A. BURIAL CREMATION REMOVAL (Specify) CREMATION | | 24B. DATE 12/24/66 | | 24C. NAME OF CEMETERY OR CREMATORY Lee Crematory | |
| 24D. LOCATION (City, town, or county) D.C. | | 24E. NAME OF REGISTRAR Robert E. Barnes | | 24F. FUNERAL DIRECTOR Robert E. Barnes, Severna Park Md | |
| 24G. DATE REC'D BY HEALTH DEPT. | | 24H. NAME OF REGISTRAR | | 24I. FUNERAL DIRECTOR | |



FUNERAL DIRECTOR: IMPORTANT

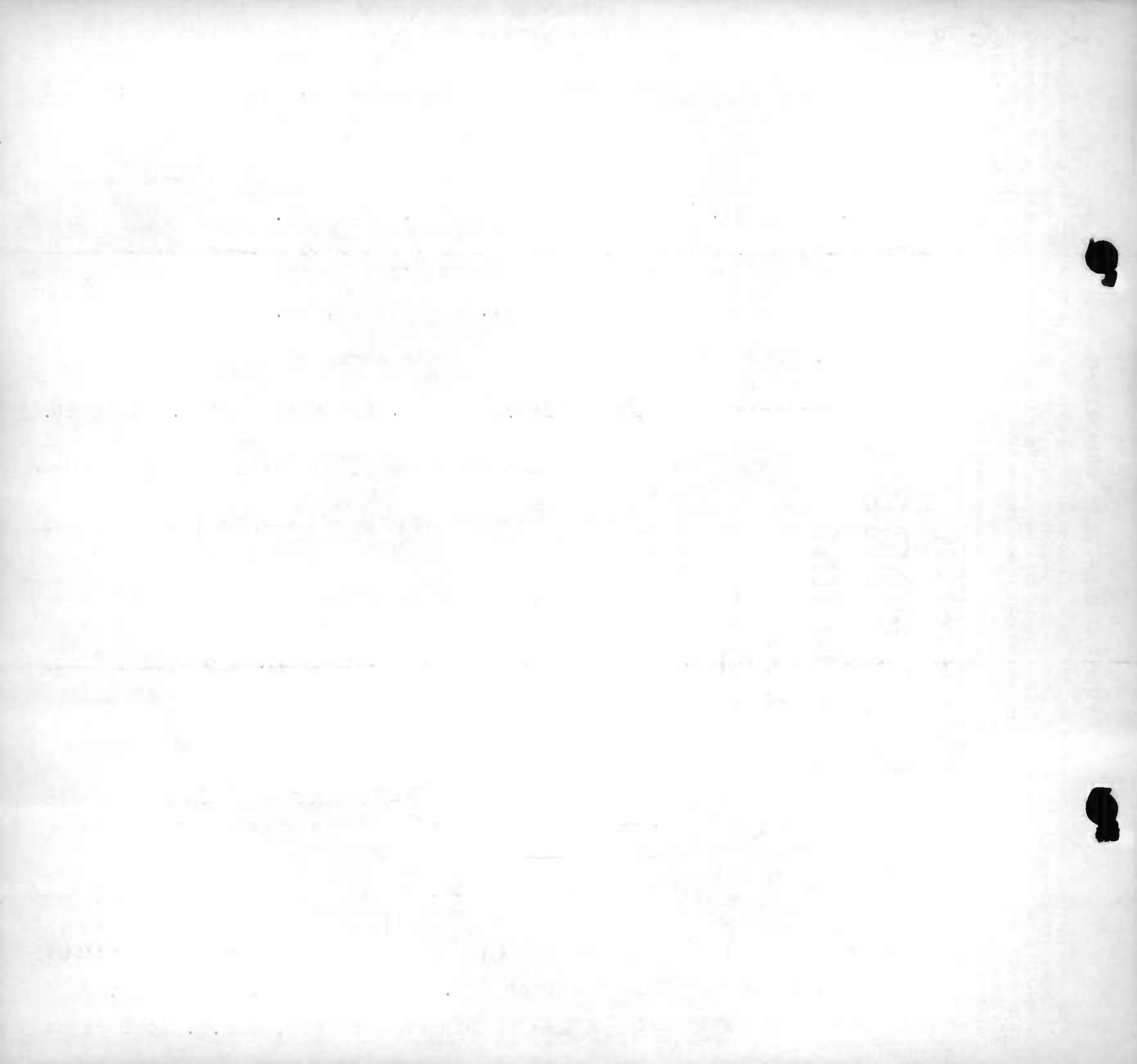
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 12933 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12933 | |
|--|-------------------------|--|-------------------------------------|---|--|--|-----------------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Philip C. Hettchen, SR. | | | | 2. DATE AND HOUR OF DEATH 12-20-66 1:30 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore General Hosp. | | (If not in hospital or institution, give street address or location) | | A. STATE Maryland | | B. COUNTY BALTIMORE Co. | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #21224 HARBOR VIEW | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 533 S. 48th. St. 53-00 | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 4-1-1904 | 9. AGE (in years last birthday) 62 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | 10B. KIND OF BUSINESS OR INDUSTRY STAND. OIL CO. | | 11. BIRTHPLACE (State or foreign country) Balto., Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Conrad Hettchen | | | | 14. MOTHER'S MAIDEN NAME Katherine Malkus (MALKUS) | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. 214-01-4453 | | 17. INFORMANT ADDRESS MARY D. HETTCHEN SAME | |
| 18. 331X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Cerebral Hemorrhage ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hypertension | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 36 hours | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (this hospital) attended the deceased from 12-17 1966 to 12-20 1966 , that (we) last saw the deceased alive on 12-20 1966 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE William F. Bruther M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-20-66 | |
| 23C. PHYSICIAN'S NAME (Type) William F. Bruther M.D. | | | | 23D. ADDRESS 1213 Light St. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12-23-66 | | 24C. NAME OF CEMETERY or CREMATORY OAK LAWN CEM. | | 24D. LOCATION (City, town, or county) (State) 7225 EASTERN BLVD. BALTO. CO., MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | 25B. NAME OF REGISTRAR Charles S. Gailer | | 25C. FUNERAL DIRECTOR ADDRESS 6224 EASTERN AVE. BALTO., 21224, MD. | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12934 | |
|--|-----------------------------|--|--|--|--|
| BIRTH NO. 66 12934 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) George Charles Schuckert | | 2. DATE AND HOUR OF DEATH Dec 22, 1966 1 5:20 P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 00 | | A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 7-05 D. STREET ADDRESS (If rural, give location) 531 N. Wolfe St. | | | |
| 5. SEX Male | 6. RACE Caucasian | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH April 8, 1893 | 9. AGE (In years last birthday) 73 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Post Office Clerk | | 10B. KIND OF BUSINESS OR INDUSTRY John Hopkins Univ. | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | |
| 13. FATHER'S NAME George D. Schuckert | | 14. MOTHER'S MAIDEN NAME Annie Jaecksch | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 212-05-3829 | | 17. INFORMANT Louise R. Schuckert | |
| | | ADDRESS 531 N. Wolfe St. | | | |
| 18. I 157X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinoma of stomach ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Chronic nephritis (? pyelo) | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 14 months several years | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 01965 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from about Oct. 1965 to December 1966 , that (I) (we) last saw the deceased alive on Dec. 17 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Palmer H. Fletcher | | | | 23B. DATE SIGNED Dec. 23 1966 | |
| 23C. PHYSICIAN'S NAME (Type) Palmer H. Fletcher | | | | 23D. ADDRESS Johns Hopkins Hospital, Baltimore | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/26/66 | | 24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cem. | |
| 24D. LOCATION Belair Rd. Balto, Md. | | 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | | |
| 25B. NAME OF REGISTRAR John E. Fletcher | | 25C. FUNERAL DIRECTOR Dippel Brothers, Inc. | | | |
| 25D. ADDRESS 1800 | | 25E. ADDRESS E. Lombard St | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 12935 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12935 | |
|--|---------------------|---|------------------------------------|--|---------------------------------|---|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) <u>Smith, Larry Gordon</u> | | 2. DATE AND HOUR OF DEATH <u>12/21/66</u> <u>7 P</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>University Hospital</u> | | | | A. STATE <u>Maryland</u> B. COUNTY <u>X</u> | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> <u>4-02</u> | | | |
| | | | | D. STREET ADDRESS (If rural, give location) <u>770 W Saratoga (Apt 710)</u> | | | |
| 5. SEX <u>m</u> | 6. RACE <u>c</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <u>Single</u> | 8. DATE OF BIRTH <u>3/31/57</u> | 9. AGE (In years lost birthday) <u>9</u> | If Under 1 Yr. Months: Days: | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Leroy Smith</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Gloria Smith Battle</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT ADDRESS <u>Mrs. Gloria B. Smith. 770 W. Saratoga St. Baltimore, Md</u> | | | |
| 18. <u>550,11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) <u>Acute Perforated appendicitis</u> DUE TO (B) <u>Generalized peritonitis</u> DUE TO (C) <u>+ pelvic abscess.</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION <u>12/13/66</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Appendicitis</u> | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12/17</u> 19 <u>65</u> to <u>12/21</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12/21</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Peter S. MacMurray</u> M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>12/21/66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Peter S. MacMurray</u> | | | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>12/24/66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Gough Meth. Church Cem.</u> | | 24D. LOCATION (City, town, or county) (State) <u>Cockeysville, Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR <u>H. J. Eckhardt</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>Owings Mills, Md.</u> | | | |

1

10/10/2011 2:11:11

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6161

20 01/01 20

Patent No. 1000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 12936 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12936 | |
|--|---------------------|---|--|--|---|
| M.E. CASE NO. | | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) <u>Jerry Brandt Caldwell</u> | | | 2. DATE AND HOUR OF DEATH <u>December 20 1966 5:15 A.M.</u> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>University of Maryland Hospital</u> | | | A. STATE <u>Maryland</u> B. COUNTY <u>Washington county</u> | | |
| (If not in hospital or institution, give street address or location) | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Hagerstown</u> | | |
| | | | D. STREET ADDRESS (If rural, give location) <u>71-03</u> <u>1029 MAIN AVE.</u> | | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Never married</u> | 8. DATE OF BIRTH <u>10/2/63</u> | 9. AGE (In years last birthday) <u>3</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u> | | | 11. BIRTHPLACE (State or foreign country) <u>Md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME <u>Jerry Lee Caldwell</u> | | | 14. MOTHER'S MAIDEN NAME <u>Connie Belt</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | 16. SOCIAL SECURITY NO. <u>-</u> | | 17. INFORMANT <u>Mother</u> |
| | | | | | ADDRESS <u>S/A/A</u> |
| 18. <u>237X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Brain tumor, post. fossa</u> | | | CAUSE OF DEATH (A) <u>Brain tumor, post. fossa</u> DUE TO | | INTERVAL BETWEEN ONSET AND DEATH <u>6 + months</u> |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) _____ DUE TO | | |
| (C) _____ | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>12/14/66</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Respiratory difficulty</u> | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-</u> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>-</u> | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>-</u> | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? <u>-</u> | |
| 22. I certify that <u>it</u> (this hospital) attended the deceased from <u>13 Dec 66</u> 19 <u>66</u> to <u>20 Dec</u> 19 <u>66</u> , that (I) <u>we</u> last saw the deceased alive on <u>20 Dec</u> 19 <u>66</u> and that in (my) <u>out</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> (did) <u>did not</u> view the body after death. | | | | | |
| 23A. SIGNATURE <u>Robert S. Holt</u> | | | | 23B. DATE SIGNED <u>20 Dec 66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Robert S. Holt</u> | | | | 23D. ADDRESS M.D. <u>University Hospital</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12/23/66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Blairs Valley Cemetery</u> | |
| | | | | 24D. LOCATION (City, town, or county) (State) <u>Washington Co., Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 27 1966</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Feltner</u> | | 25C. FUNERAL DIRECTOR <u>Margaret Rowland</u> | |
| | | | | ADDRESS <u>Clear Spring, Md.</u> | |

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12937

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Susie Oliver

2. DATE AND HOUR PRONOUNCED DEAD

12/20/66 11:20 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2425 Edmondson Ave.

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

widowed

8. DATE OF BIRTH

12/15/97

9. AGE (In years
last birthday)

69

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

domestic

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

unknown

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

3909 13th Ave. Baltimore Md

18. E812.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Hemoperitoneum

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

Laceration of spleen

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Edmondson and Warwick

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

12 19 66 6:22p.m.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

pedestrian struck by truck

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/20/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

12/30/66

23C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore Md

24A. DATE REC'D BY HEALTH DEPT.

DEC 27 1966

24B. NAME OF REGISTRAR

J. E. Spitz

24C. FUNERAL DIRECTOR

Altha L. McCarroll

ADDRESS

2302 W. North Ave



1
G 650

66 12938

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12938

| | | | |
|---|---------|--|------------------|
| BIRTH NO. | | M.E. CASE NO. | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR PRONOUNCED DEAD | |
| FRED DOUGLAS GREEN | | December 21, 1966 4:34 P M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE Maryland | |
| 33 Johns Hopkins Hospital | | B. COUNTY 8-03 | |
| C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | | D. STREET ADDRESS (If rural, give location) | |
| Baltimore | | 1406 N. Milton Avenue | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH |
| Male | Negro | SINGLE | 10-15-43 |
| 9. AGE (In years last birthday) | | 10. KIND OF BUSINESS OR INDUSTRY | |
| 23 | | Construction | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Charlotte Co., Va. | | U. S. A. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| Lenwood Green | | Cecelia Madison | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| NO | | | |
| 17. INFORMANT | | ADDRESS | |
| Mrs Cecelia Green | | 1406 N. Milton Ave. | |
| 18. CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | |
| A. Status Epilepticus DUE TO | | | |
| II ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | B. Craniocerebral Injury. DUE TO | |
| C. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 2 | | | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| Yes | | Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| | | Street | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | |
| Broadway and Ashland St. | | 5 9 1959 | |
| 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | Pedestrian struck by auto. | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE | | DATE SIGNED | |
| Charles S. Petty | | 12/22/66 | |
| EXAMINER'S NAME (Type) | | M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| Charles S. Petty | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | |
| Burial | | 12-24-66 | |
| 23C. NAME of CEMETERY or CREMATORY | | 23D. LOCATION (City, town, or county) (State) | |
| Mt. Calvary Cmt'y. | | Anne Arundel Co., Md. | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | |
| DEC 27 1966 | | Raudolph J. Collick | |
| 24C. FUNERAL DIRECTOR | | ADDRESS | |
| Raudolph J. Collick | | 2431 E. Oliver St. | |

12-12-44

single

Robertson
Cecilia Mason

Robertson
Cecilia Mason

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12939 | |
|---|-------------------------|--|-----------------------------------|---|---|
| BIRTH NO. 66 12939 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Howard Voorhees</i> | | 2. DATE AND HOUR OF DEATH <i>Dec 24 - 1966 6.30 A.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>26-44</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Church Home & Hospital</i> <i>35</i> | | (If not in hospital or institution, give street address or location) | | D. STREET ADDRESS (If rural, give location) <i>407 N. Highland Ave.</i> | |
| 5. SEX <i>Male</i> | 6. RACE <i>White</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i> | 8. DATE OF BIRTH <i>1-2-93</i> | 9. AGE (in years lost birthday) <i>72</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Brooklyn, N.Y.</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>American</i> | | 13. FATHER'S NAME <i>Unknown</i> | | 14. MOTHER'S MAIDEN NAME <i>Unknown</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> W.W. One | | 16. SOCIAL SECURITY NO. <i>Unknown</i> | | 17. INFORMANT <i>Roy Diefenbach</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>420.01x-260x</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Diabetes Mellitus</i> | | CAUSE OF DEATH (A) DUE TO <i>Cerebrovascular Accident</i> <i>Thrombosis</i> (B) DUE TO <i>Arteriosclerotic Heart Disease</i> (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH <i>days</i> <i>year</i> <i>year</i> | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>12-3-</i> 19 <i>66</i> to <i>Dec. 24-</i> 19 <i>66</i> , that (I) (we) lost saw the deceased alive on <i>Dec. 24th</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>A. E. Subkig, Jr.</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Still Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>12-24-66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Dr. A. E. SUBKIG, JR.</i> | | 23D. ADDRESS <i>Church Home & Hospital</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12/29/66</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Evergreen Cemetery</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Brooklyn, New York</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 27 1966</i> | | | |
| 25B. NAME OF REGISTRAR <i>John E. ...</i> | | 25C. FUNERAL DIRECTOR <i>Wm. Cook Brooks, Inc., 1217 St. Paul St. Baltimore 2, Maryland</i> | | | |

Church Home & Hospital

Mrs. White Widowed

Retired

Unknown

403 Highland Ave
Baltimore

1-2-23 75

Alone

Unknown

Ray Diehard 2nd

Constitutional
Therapy
Gymnasium
Baltimore

Therapeutic

cc Dec 24

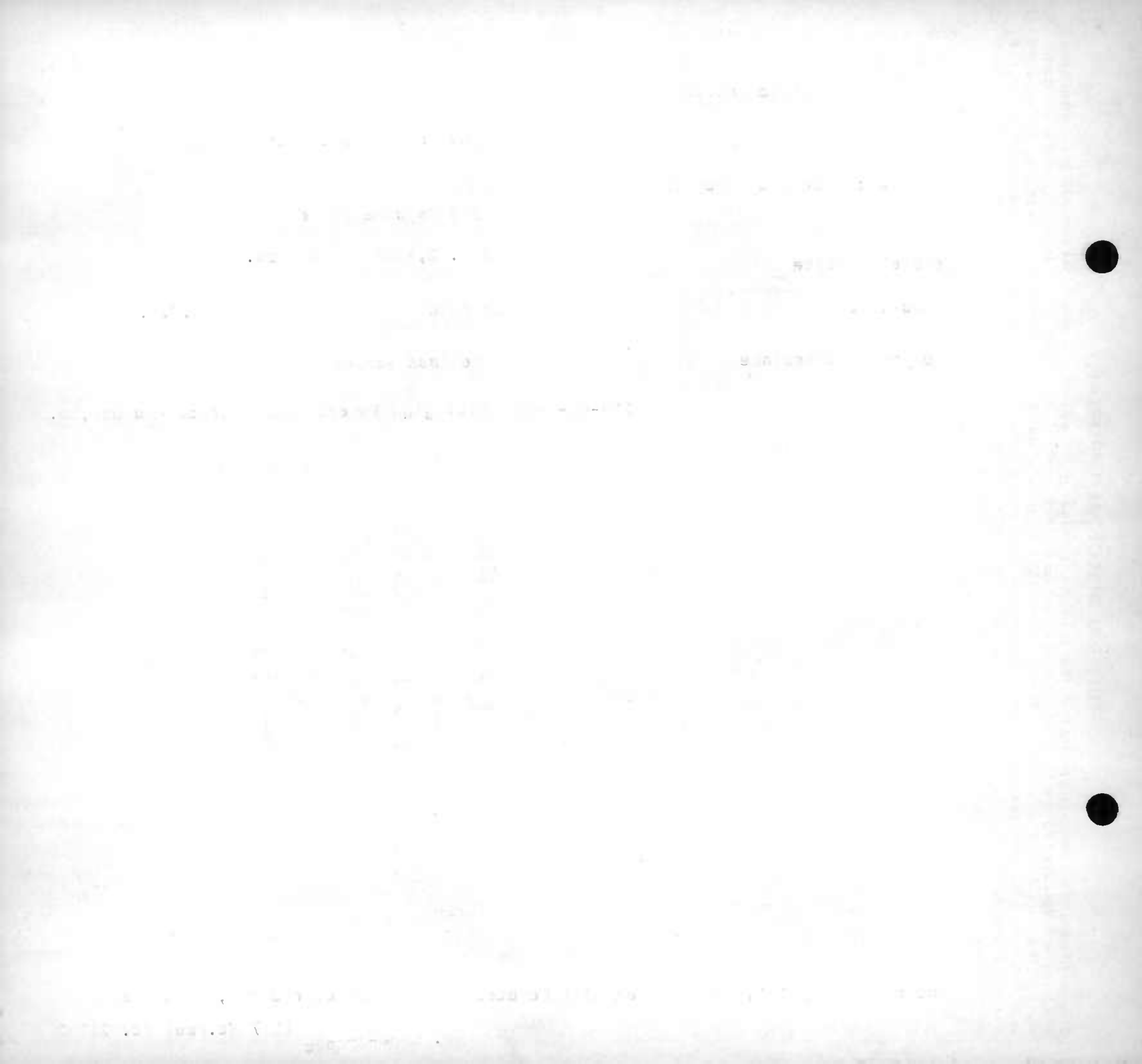
Dec 24 1923

Dr. A. E. Sweeney
12-24-23

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

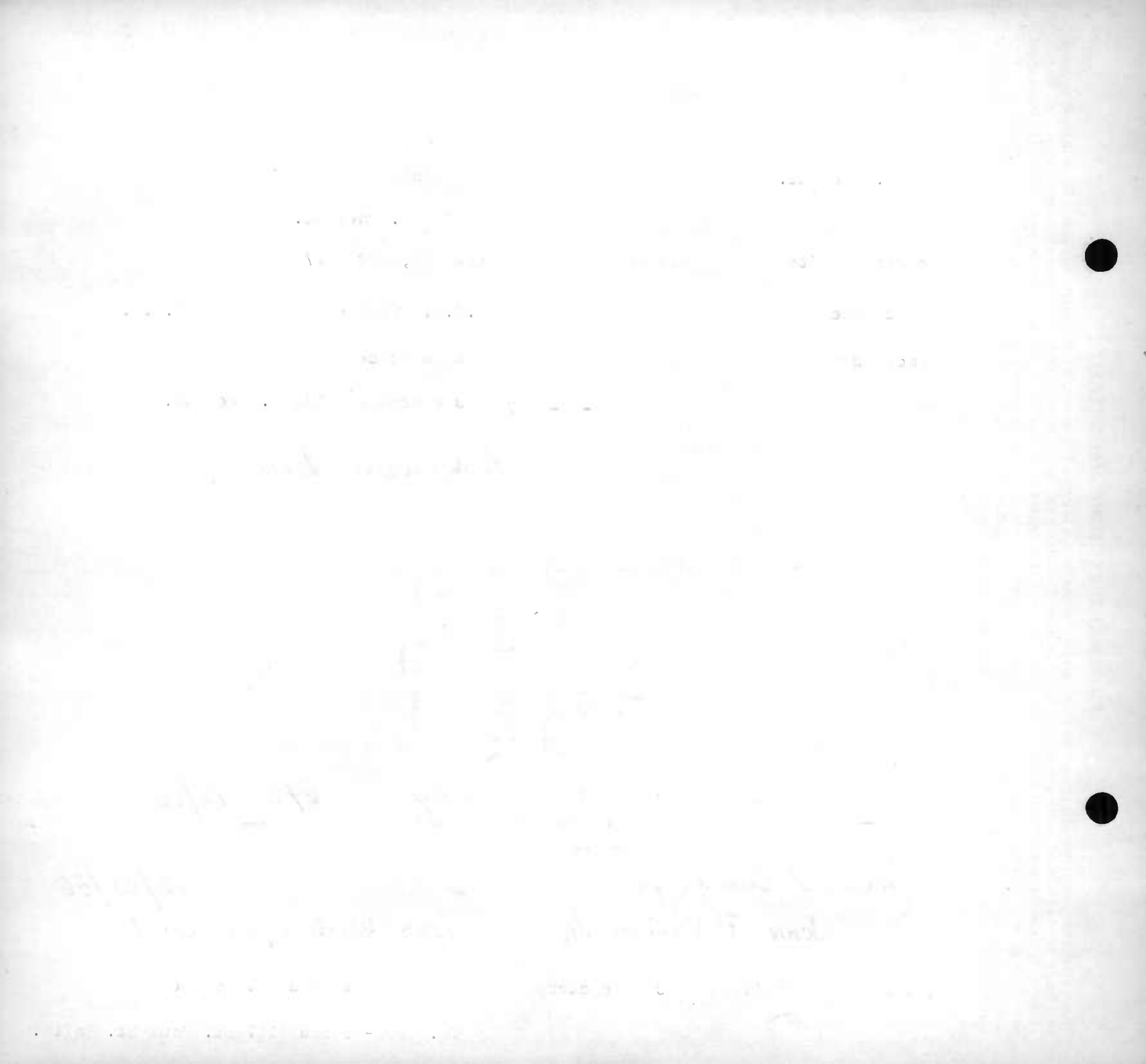
| BALTIMORE CITY HEALTH DEPARTMENT | | | | X | | Registered No. | |
|---|--------------|--|---------------------|--|----------------------------|--|--|
| BIRTH NO. 66 12940 | | CERTIFICATE OF DEATH | | | | Registered No. 66 12940 | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Mollie Harding | | | | Dec 23-66 at 8³⁰ P M | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE Maryland B. COUNTY Baltimore Co. | | | |
| 31 Baltimore City Hospital | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) 53-00 | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 553 Bayside Drive | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | If Under 1 Yr. Months Days | | |
| Female | White | ? | Aug. 2, 1885 | 81 Yrs. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Housewife | | ? | | Virginia | | U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Benjamin Timberlake | | | | Melissa Bagley | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| No | | 229-68-0660 | | Elkinslum Funeral Home Fredericksburg, Va. | | | |
| 18. CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | | | Acute Myocardial Infarction | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) DUE TO (B) DUE TO (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 0 | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from August 19 66 to Dec. 23 19 66 , that (I) (we) last saw the deceased alive on Dec 23 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Marcos Levin | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 12/24/66 | |
| 23C. PHYSICIAN'S NAME (Type) MARCOS LEVIN | | | | 23D. ADDRESS 201 Wise Ave Balto 22 Md | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 12/27/66 | | Oak Hill Cemetery | | Fredericksburg, Virginia | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| DEC 27 1966 | | Wm. Cook Brooks | | 1217 St. Paul St. 21202 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 12941</u> | |
|--|-------------------------|--|---|--|---|
| BIRTH NO. <u>66 12941</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>MARTHA JANE JOHNSON</u> | | 2. DATE AND HOUR OF DEATH <u>Dec 22, 1966</u> <u>10 P.</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>316 N. Paca St.</u> | | A. STATE <u>Maryland</u> B. COUNTY <u>4-02</u> | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | | |
| | | D. STREET ADDRESS (If rural, give location) <u>316 N. Paca St.</u> | | | |
| 5. SEX <u>Female</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>March 16, 1889</u> | 9. AGE (In years last birthday) <u>77</u> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) <u>U.S.A. Kentucky</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>Jack Ison</u> | | | 14. MOTHER'S MAIDEN NAME <u>Hanna Creech</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>401-14-0487</u> | 17. INFORMANT ADDRESS <u>Elsie Armiger 316 N. Paca St.</u> | | |
| 18. <u>350X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) <u>Parkinson Disease</u> DUE TO (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH <u>5 year</u> | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12/17</u> 19 <u>64</u> to <u>12/22</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec 20</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) did not view the body after death. | | | | | |
| 23A. SIGNATURE <u>John P. Urlock Jr</u> | | | | 23B. DATE SIGNED <u>12/23/66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>JOHN P. URLOCK JR</u> | | | | 23D. ADDRESS <u>1227 Washington Blvd</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12/27/66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Ison Cemetery</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Stevens Co. Kentucky</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 27 1966</u> | | 25B. NAME OF REGISTRAR <u>P. E. ...</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>Wm. Cook-Brooks 1217 St. Paul St. Balto.</u> | |



CERTIFICATE OF DEATH

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|---------|--|--|--|------------------------------------|--|--|
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | | | STEPHENS, THELMA M. | | Dec. 23, 1966. 4.05 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | A. STATE | | B. COUNTY | |
| 31/BALTIMORE CITY HOSPITAL | | 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224 | | Maryland Baltimore City | | 246-11 | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Baltimore City. 21224-007. | |
| | | | | D. STREET ADDRESS (If rural, give location) | | 1203 S. Bouldin St. 21224 | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months Days | |
| Female | White | Married | | 10/6/20 | 46 yrs. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Housewife | | None | | MARYLAND | | USA | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| JOHN FREY | | | | Norma Agnew | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| No | | Unknown | | RECORDS-BCH | | 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | (A) DUE TO | | | |
| ANTECEDENT CAUSES | | | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | ① High blood pressure ② Chronic Renal disease | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| Dec. 23, 1966 | | ① Intra Cerebral hematoma | | YES | | YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | | (If in Baltimore City, give exact location) | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (if this hospital) attended the deceased from Dec 21, 1966 to Dec 23, 1966, that (I) last saw the deceased alive on 12/23/66, 19 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| C. Bhushan | | | | | | 12/23/66 4.15 P.M. | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| DR. CHHABI BHUSHAN | | | | BALTIMORE CITY HOSPITAL, BALTIMORE 24 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 12/28/66 | | Baltimore National Cemetery | | Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| DEC 27 1966 | | Wm. Cook-Brooks F.H. | | Balto. Md. 21202 | | 1217 St. Paul St. | |

PORTSMOUTH CITY HOSPITAL

James - Cable - 10/6/30

1932 2 10/6/30

10/6/30

①

With blood pressure
② James - Cable - 10/6/30

10/6/30 ③ James - Cable - 10/6/30

Chandler

CHANDLER, BERNARD

X

PORTSMOUTH CITY HOSPITAL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|-------------------------|--|---|--|--|---|--|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. <u>66 12943</u> | | | | |
| BIRTH NO. <u>66 12943</u> | | | | | | | | | |
| M.E. CASE NO. <u>66 12943</u> | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>TRITSINIS, MICHAEL D.</u> | | | | | 2. DATE AND HOUR OF DEATH <u>2:00 pm Dec 25 1966</u> M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>The Union Memorial Hospital</u> | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>12-06</u> | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) <u>2402 ST. PAUL ST.</u> | | | | |
| 5. SEX <u>M</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>M</u> | 8. DATE OF BIRTH <u>02-18-92</u> | 9. AGE (In years last birthday) <u>74</u> | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>GREECE</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u> | | |
| 13. FATHER'S NAME <u>Unknown</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | 16. SOCIAL SECURITY NO. <u>213-14-5200</u> | | 17. INFORMANT <u>Lillian K. Tritsinis, Baltimore, Maryland</u> | | | | |
| 18. <u>165-X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Metastatic lung Ca.</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASCVD</u> | | | | | CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>7:25 PM Dec 24 1966</u> to <u>2:00 PM Dec 25 1966</u> , that (I) (we) last saw the deceased alive on <u>2:00 PM Dec 25 1966</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>Sang Won Song</u> | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>Dec 25 1966</u> | | |
| 23C. PHYSICIAN'S NAME (Type) <u>DR SANG WON SONG</u> | | | | | 23D. ADDRESS M.D. <u>THE UNION MEMORIAL HOSPITAL</u> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u> | | 24B. DATE <u>12/27/1966</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Green Mount Crematory</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 27 1966</u> | | | 25B. NAME OF REGISTRAR <u>R. E. Johnson</u> | | 25C. FUNERAL DIRECTOR <u>Wm. Cook-Brooks, Inc., 1217 St. Paul St. Baltimore, Maryland</u> | | | | |

2000 Dec 22

TRISTAN'S MICHAIL

M

2000 Dec 22

2000 Dec 22

2000 Dec 22

AMERICAN

GRACE

Unknown

The Union Memorial Hospital

M White M

Unknown

Metastatic lung Ca.

ASCD

to

2000 Dec 22 2000 Dec 22 2000 Dec 22

2000 Dec 22

Hand over hand

2000 Dec 22

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 12944</u> | |
|--|------------------------------|--|--|---|---|
| BIRTH NO. <u>66 12944</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Simom Milton Eberenz</u> | | 2. DATE AND HOUR OF DEATH <u>DEC. 21, 1966</u> <u>6 A. M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>00 916 Argonne Drive 21218</u> | | A. STATE <u>Maryland</u> B. COUNTY <u>9-01</u> | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | | |
| | | D. STREET ADDRESS (If rural, give location) <u>916 Argonne Drive 21218</u> | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u> | 8. DATE OF BIRTH <u>Sept. 2, 1896</u> | 9. AGE (In years lost birthday) <u>70</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Bemson Fuel Co.</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore City</u> | |
| 13. FATHER'S NAME <u>William Eberenz</u> | | 14. MOTHER'S MAIDEN NAME <u>Clara Miller</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>376-05-9853</u> | | 17. INFORMANT ADDRESS <u>Mr. Paul Jendrek 8129 Oakleigh Rd. 21234</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>443X I</u> <u>Hypertensive Cardiovascular Dis</u> | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs +</u> | |
| 19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Cerebral Arteriosclerosis {with several CVA & senility}</u> | | <u>6 yrs +</u> | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>JAN. 27 1961</u> to <u>DEC. 21 1966</u> , that (I) (we) last saw the deceased alive on <u>OCT. 31 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Robert W. Garis</u> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>DEC. 22, 1966</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>ROBERT W. GARIS,</u> | | 23D. ADDRESS M.D. <u>12 EAST EAGER ST., BALTIMORE, MD. 21202</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | 24B. DATE <u>12-23-66</u> | 24C. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Parkville Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 27 1966</u> | | 25B. NAME OF REGISTRAR <u>R. E. Zeller</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>Wm. Cook-Brooks Towson Inc. 1050 York Rd. Towson, Md.</u> | |

100-100000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 12945 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 66 12945 | |
|---|-------------------------|--|---|---|---|---|--|--|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) PRZYBYLSKI ANTHONY T. | | 2. DATE AND HOUR OF DEATH 12/23/66 730 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALT. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALT. | | D. STREET ADDRESS (If rural, give location) 3140 WOODRING AVE. | |
| FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIV. HOSP. | | | | (If not in hospital or institution, give street address or location) | | | | | |
| 5. SEX M | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE | 8. DATE OF BIRTH 4/15/01 | 9. AGE (In years last birthday) 65 | 10. Under 1 Yr. Months Days | 11. Under 24 Hrs. Hours Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PIANO TUNER | | | 10B. KIND OF BUSINESS OR INDUSTRY HECHT CO. | | 11. BIRTHPLACE (State or foreign country) MD. | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME ? FRANCIS PRZYBYLSKI | | | | 14. MOTHER'S MAIDEN NAME ? ANTONINA MAKOWIECKI | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. 215-01-8251 | | 17. INFORMANT ADDRESS PT. 2020 PORTUGAL ST. | | | |
| 18. 4201 I | | | | CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) | | | | (A) MYOCARDIAL INFARCT | | | | 48 hr | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) — | | | | | |
| | | | | (C) — | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/22/66 19 to 12/23/66 19 that (I) (we) last saw the deceased alive on 12/23/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE H. K. Wallace | | | | M.D. | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/23/66 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | M.D. | | 23D. ADDRESS | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12/27/66 | | 24C. NAME of CEMETERY or CREMATORY ST. STANISLAUS | | 24D. LOCATION (City, town, or county) (State) BALTIMORE MD. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | 25B. NAME OF REGISTRAR George E. Weber | | 25C. FUNERAL DIRECTOR George E. Weber | | ADDRESS 705 S. Ann St. | | | |

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TIME

Hecht Co.

No

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12946 | |
|--|-------------------------|--|------------------------------------|---|---|
| BIRTH NO. 66 12946 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) BIEL Mr. GEORGE WOJCIECH | | 2. DATE AND HOUR OF DEATH 12/24/66 2-25p M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) Church home hospital 35 100 N. Broadway Baltimore Md. | | D. STREET ADDRESS (If rural, give location) 736 S. Curley St. | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 4-11-83 | 9. AGE (In years lost birthday) 83 yrs | 10. Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer | | 10B. KIND OF BUSINESS OR INDUSTRY Self Emp. | | 11. BIRTHPLACE (State or foreign country) Poland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Leon Biel | | 14. MOTHER'S MAIDEN NAME Mary Ann Zajac | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown | | 16. SOCIAL SECURITY NO. 216-46-297 | | 17. INFORMANT Dr. R-M. Anandach | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) C.V.A. | | INTERVAL BETWEEN ONSET AND DEATH 12-20-66 | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Subarachnoid haemorrhage Bilateral pneumonia | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-20-1966 to 12-24-1966 , that (I) (we) lost saw the deceased alive on 12-24-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE  | | | | 23B. DATE SIGNED 12-24-66 | |
| 23C. PHYSICIAN'S NAME (Print) DR. A.E. SABORIS JR. | | | | 23D. ADDRESS Church Home Hosp | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12/28/66 | | 24C. NAME OF CEMETERY OR CREMATORY ST. STANISLAUS | |
| 24D. LOCATION (City, town, or county) (State) BALTIMORE MD | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | 25B. NAME OF REGISTRAR George A. Weber | | 25C. FUNERAL DIRECTOR ADDRESS 205 S. Ann St | |

211 in George Washington
 211 in George Washington

Male White Horse
 Grover
 Green Bird
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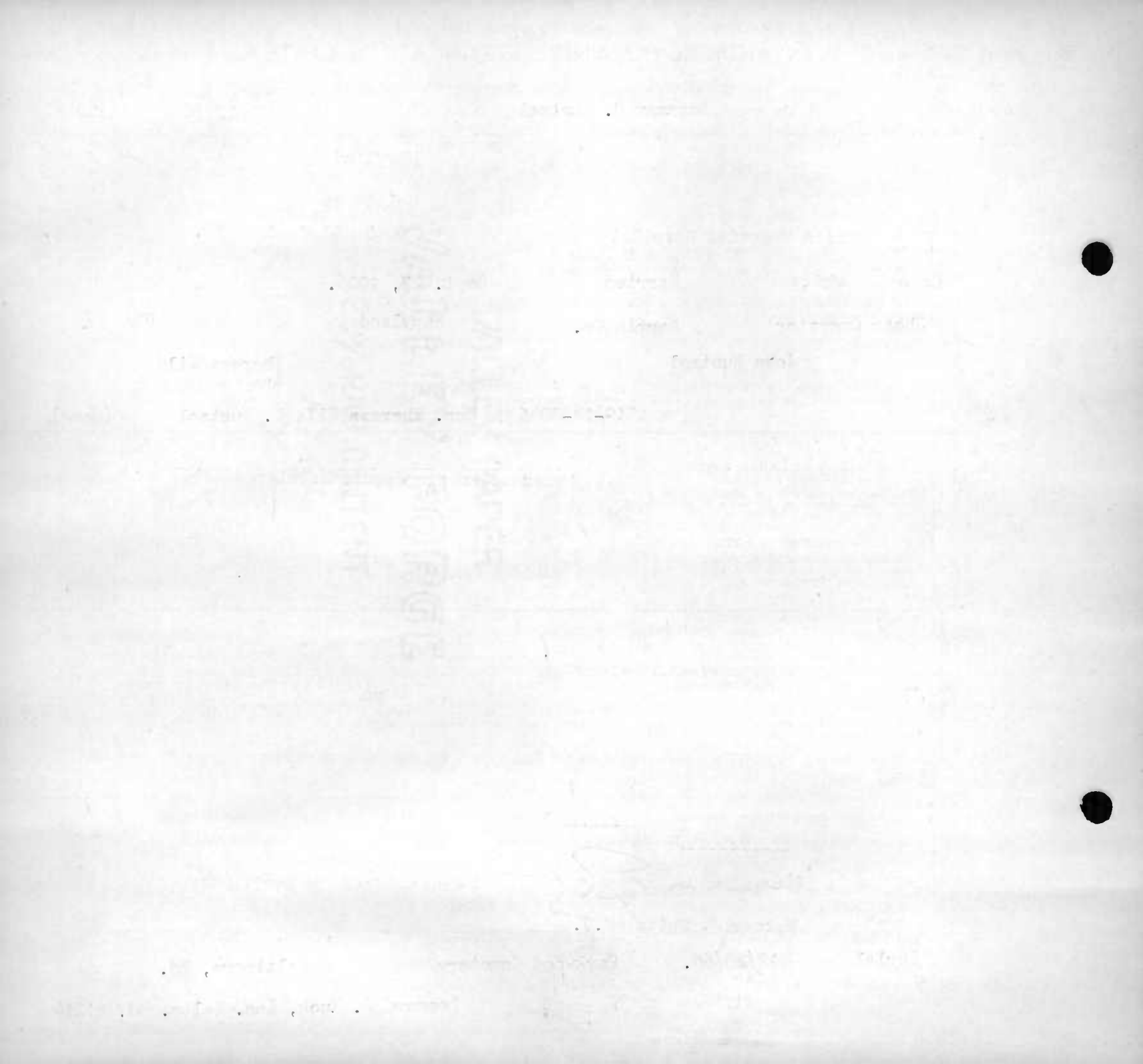
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12947

BIRTH NO.

M.E. CASE NO.

| | | | | | | |
|--|------------------|---|--|--|---|--|
| 1. NAME OF DECEASED (Type or Print) George Nuetzel C. Nuetzel | | 2. DATE AND HOUR PRONOUNCED DEAD 12/25/66 11:50 a. M. | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 27-07 C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 6013 Old Harford Rd. | | | | |
| 5. SEX male | 6. RACE white | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH Sept. 23, 1906. | 9. AGE (In years last birthday) 60 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shear Operator | | 10B. KIND OF BUSINESS OR INDUSTRY Martin Co. | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME John Nuetzel | | | 14. MOTHER'S MAIDEN NAME Theresa Wild | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 219-18-2045 | | 17. INFORMANT Mrs. Theresa Ella L. Nuetzel (Same) | | ADDRESS |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Werner U. Spitz</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/26/66 | | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 12/28/66. | | 23C. NAME of CEMETERY or CREMATORY Parkwood Cemetery | | 23D. LOCATION (City, town, or county) (State) Baltimore, Md. |
| 24A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | 24B. NAME OF REGISTRAR <i>Robert E. Fisher</i> | | 24C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214 | | ADDRESS |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12948 | |
|--|------------------|--|--|--|--|
| <div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. 66 12948</p> <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) <i>Gregory, Harry</i> (Harry L. Gregory)</p> </div> <div> <p>2. DATE AND HOUR OF DEATH <i>6:40 PM 7/24/66</i> M.</p> </div> </div> | | | | | |
| <p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>48 Maryland Gen Hospital</i></p> | | | <p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE <i>Md</i> B. COUNTY <i>Balto Co.</i></p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balto</i></p> <p>D. STREET ADDRESS (If rural, give location) <i>2929 Knoll Acres Dr.</i></p> | | |
| 5. SEX <i>M</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>W</i> | 8. DATE OF BIRTH <i>5/2/91</i> | 9. AGE (In years last birthday) <i>75</i> | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Ret</i> | | 11. BIRTHPLACE (State or foreign country) <i>N.C.</i> | |
| 13. FATHER'S NAME (Major Gregory) <i>Major Gregory</i> | | | 14. MOTHER'S MAIDEN NAME (Sarah Williams) <i>Sarah Williams</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>213-03-7388</i> | | 17. INFORMANT ADDRESS <i>Norwood L. Gregory, 2931 Knoll Acres Dr.</i> | |
| 18. <i>443X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | CAUSE OF DEATH | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | (A) <i>Hypertensive cerebrovascular disease</i> | | |
| ANTECEDENT CAUSES | | | (B) <i>Hypertensive cardiovascular arteriosclerotic disease</i> | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (C) _____ | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>yes</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>12/22/65</i> 19 to <i>12/28</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>12/24/66</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Daniel C. Wilkerson</i> M.D. | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) <i>Daniel C. Wilkerson</i> M.D. | | | | 23D. ADDRESS <i>421 E. Gester Ave Balto Md</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12-28-66</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Parkwood</i> | |
| 24D. LOCATION (City, town, or county) <i>Balto., Md.</i> | | 24E. (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 27 1966</i> | | 25B. NAME OF REGISTRAR <i>E. J. Ruck</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>Leonard J. Ruck, Inc., 5305 Harford Rd.</i> | |

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|--|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 86 12949 | |
| BIRTH NO. 66 12949 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) William F. Rock | |
| 2. DATE AND HOUR OF DEATH Dec. 26, 1966. 6:30 A. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND CERTIFICATE AMENDED FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 12-29-66 1621 E. 32 nd. St. | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 9-06 | |
| 5. SEX Male | | 6. RACE White | |
| 7. MARRIED, NEVER MARRIED WIDOWED (specify) | | 8. DATE OF BIRTH 1879 Jan. 13, 1896 | |
| 9. AGE (In years lost birthday) 87 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Woodworking Business | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME William Rock | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 217-32-8915 | |
| 17. INFORMANT Mr. Raymond W. Rock | | ADDRESS (Same) | |
| 18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Acute myocardial infarction DUE TO 5 minutes (B) Generalized arteriosclerosis DUE TO 30 years (C) _____ | |
| INTERVAL BETWEEN ONSET AND DEATH | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notly medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1959 to Dec 26 19 66 , that (I) (we) last saw the deceased alive on Dec 23 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Seymour H. Rubin | | 23B. DATE SIGNED Dec 27 1966 | |
| 23C. PHYSICIAN'S NAME (Type) Seymour H. Rubin | | 23D. ADDRESS 5415 Park Heights Ave | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/29/66 | |
| 24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Cem. | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | 25B. NAME OF REGISTRAR Robert E. Saylor | |
| 25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. | | ADDRESS 21214 | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | Registered No. 66 12950 | |
|---|--|--|--|--|--|
| BIRTH NO. 66 12950 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) DAIKEY, EVA C. | |
| 2. DATE AND HOUR OF DEATH 12-26-66 10¹⁵ A.M. | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION 90 Bolton Hill NURSING Home (If not in hospital or institution, give street address or location) | | | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD B. COUNTY 27-01 | | 5. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, | | | |
| 6. STREET ADDRESS (If rural, give location) 4108 MARX AVE | | 7. DATE OF BIRTH 12-14-1885 9. AGE (In years last birthday) 81 | | | |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERICAL WORKER READY OPERATOR | | 11. BIRTHPLACE (State or foreign country) PENNA. | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME JOHN DAIKEY | | 14. MOTHER'S MAIDEN NAME CATHERINE CROWLEY | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 047-07-7704 | | 17. INFORMANT ADDRESS 5070 WRIGHT AVE. CATHERINE STRATMEYER | |
| 18. 475X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PNEUMONIA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) PNEUMONIA (B) (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. OLD CEREBRAL VASCULAR ACCIDENT | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/8/66 19 to 12/26/66 19, that (I) (we) last saw the deceased alive on 12/26/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE  | | 23B. DATE SIGNED 12/26/66 | | 23C. PHYSICIAN'S NAME (Type) HOLLIS SENNARINE | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/28/66. | | 24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery | |
| 24D. LOCATION Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | 25B. NAME OF REGISTRAR Robert E. Fairbank | |
| 25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214 | | 25D. ADDRESS | | | |

Present

Dr. Charles Vernon Smith

10/2/22

10/2/22

10/2/22

10/2/22

John D. Smith
President

for Treasurer 25th

66 12951

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 12951

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WALTER L. CLARK

2. DATE AND HOUR PRONOUNCED DEAD

Dec 23 66

8²⁰ P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

CERTIFICATE AMENDED

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

2-2-67

44 Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2709 Montebello Terrace

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

January 8, 1933.

9. AGE (In years
lost birthday)

33

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Metal Installer

10B. KIND OF BUSINESS OR INDUSTRY

Doors

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

William Clark

14. MOTHER'S MAIDEN NAME

Alice Cooper

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

213-30-9132

17. INFORMANT

Mrs. Carolyn M. Clark

ADDRESS

(Same)

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Pulmonary edema and acute bronchopneumonia

(A) Acute Ethylism due to Acute Ethylism

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Arteriosclerotic heart disease

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12. 24 66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/28/66.

23C. NAME OF CEMETERY or CREMATORY

Baltimore, Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

DEC 27 1966

24B. NAME OF REGISTRAR

Robert E. Jackson

24C. FUNERAL DIRECTOR

Leonard J. Ruck, Inc. Balto. Md. 21214

ADDRESS

VALLEY FORCE

VALLEY FORCE

VALLEY FORCE

VALLEY FORCE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

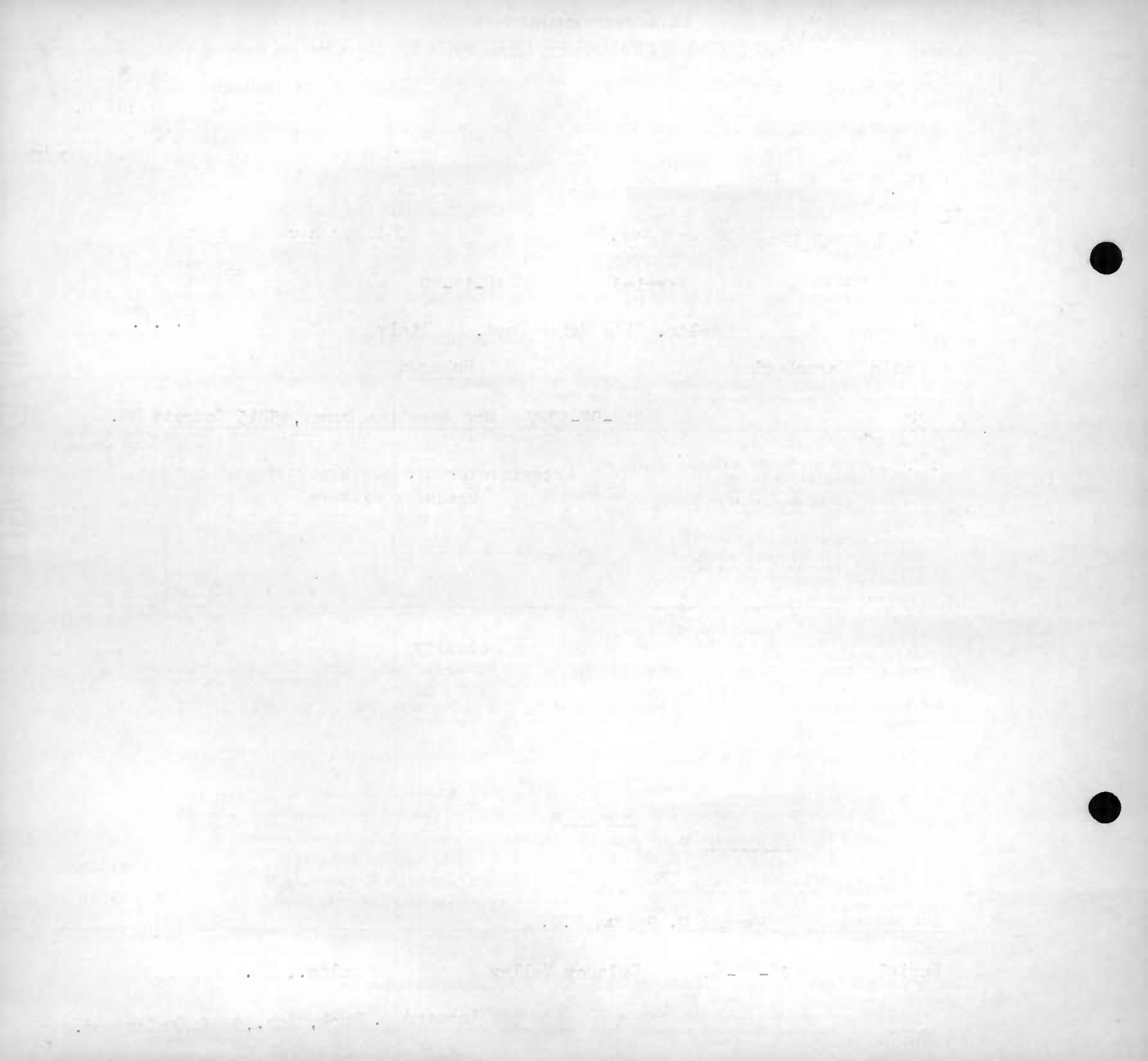
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12952 | |
|--|-------------------------|--|---|--|--|
| BIRTH NO. 66 12952 | | | | M.E. CASE NO. | |
| 1. NAME OF DECEASED (Type or Print) WILLIAM J. BURGAN | | | 2. DATE AND HOUR OF DEATH DECEMBER 24, 1966. 9A M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Harford Gardens Nursing Home | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 27-05 | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #34 | | |
| | | | D. STREET ADDRESS (If rural, give location) 3103 Chesley Ave. | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED Single | 8. DATE OF BIRTH June 9, 1882 | 9. AGE (In years last birthday) 84 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Poultry Dealer | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME William H. Burgan | | | 14. MOTHER'S MAIDEN NAME Emma Banks | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 214-34-3794A | | 17. INFORMANT Mrs. Mabel Nonemaker | |
| | | | | ADDRESS (Same) | |
| 18. 181.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) Metastatic Carcinoma 2 months DUE TO PAPILLARY CARCINOMA Bladder 3 YEARS (B) CORONARY INSUFFICIENCY 6 M.O.S DUE TO ARTERIOSCLEROTIC HEART 2 YEARS (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (the physician) attended the deceased from Feb. 1959 to 12/24 19 66 , that (I) was last saw the deceased alive on 12/23 19 66 and that in (my) my opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE John H. Hirschfeld M.D. | | | | 23B. DATE SIGNED 12/24/1966 | |
| 23C. PHYSICIAN'S NAME (Type) JOHN H. HIRSCHFELD M.D. | | | | 23D. ADDRESS 6919 HARFORD ROAD BALTIMORE 21234 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/27/66. | | 24C. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | 25B. NAME OF REGISTRAR R. J. E. Taylor | | 25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214 | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|---------------------|--|--|---|--|--|--|--|--|
| BIRTH NO. 66 12953 | | | | | CERTIFICATE OF DEATH | | | Registered No. 66 12953 | |
| 1. NAME OF DECEASED (Type or Print) <i>WILSON, ZERADA E.</i> | | | | | 2. DATE AND HOUR OF DEATH <i>12-2-4-66 2:45 A.M.</i> | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>THE UNION MEMORIAL HOSP</i> | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> 8. COUNTY <i>8-01</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i> D. STREET ADDRESS (If rural, give location) <i>3411 ELMLEY AVE EIMLEY</i> | | | | |
| 5. SEX <i>F</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>WIDOWED</i> | | 8. DATE OF BIRTH <i>4-9-08</i> | 9. AGE (In years last birthday) <i>58</i> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | | | 10B. KIND OF BUSINESS OR INDUSTRY — | | 11. BIRTHPLACE (State or foreign country) <i>Mo.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>Jacob I. Still</i> | | | | | 14. MOTHER'S MAIDEN NAME <i>CORA (deceased) M. Yinger</i> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i> | | | | 16. SOCIAL SECURITY NO. <i>218-46-2310</i> | | 17. INFORMANT <i>JACOB C. WILSON</i> ADDRESS <i>6604 Birchwood Ave. Balt. Md</i> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH <i>③ Gastrointestinal Hemorrhage</i> <i>④ Hypertensive Vascular Disease</i> <i>④ Diabetes Mellitus</i> <i>① myocardial infarction, acute</i> <i>② aspiration</i> <i>None</i> | | | | INTERVAL BETWEEN ONSET AND DEATH <i>Unknown</i> <i>U.K. Bin.</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION <i>2 No</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>None</i> | | 20A. AUTOPSY? (Yes or No) <i>Yes</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>No</i> | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>No</i> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>No</i> | | | | | |
| 21D. TIME OF INJURY (APPROX.) <i>No</i> | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? <i>No</i> | | | | | |
| 22. I certify that (1) (this hospital) attended the deceased from <i>12-23-1966</i> to <i>12-24-1966</i> , that (1) (we) last saw the deceased alive on <i>12-24-1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <i>Jeff Parker</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | | 23B. DATE SIGNED <i>12-24-66</i> | | | | |
| 23C. PHYSICIAN'S NAME (Type) <i>DR JEFF PARKER</i> | | | | | 23D. ADDRESS <i>THE UNION MEMORIAL HOSP</i> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12/27/66.</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Wesley Chapel Cemetery</i> | | 24D. LOCATION (City, town, or county) (State) <i>Blue Mount, Md.</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 27 1966</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Taylor</i> | | 25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc. Balto. Md. 21214</i> | | | | | |

| BIRTH NO. <u>66 12954</u> | | BALTIMORE CITY HEALTH DEPARTMENT | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. <u>66 12954</u> | |
|---|-------------------------|---|------------------------------------|--|---|
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Charles Carnabuci</u> | | 2. DATE AND HOUR PRONOUNCED DEAD <u>12/25/66</u> <u>1:46 a.</u> <u>M.</u> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>27-44</u> | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>00</u> <u>Loch Raven and Belvedere Ave.</u> | | D. STREET ADDRESS (If rural, give location) <u>1343 Northern Parkway</u> | | | |
| 5. SEX <u>male</u> | 6. RACE <u>white</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u> | 8. DATE OF BIRTH <u>8-13-99</u> | 9. AGE (In years last birthday) <u>67</u> | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Balto. City Water Dept.</u> | | 11. BIRTHPLACE (State or foreign country) <u>Italy</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Santo Carnabuci</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>218-07-5327</u> | | 17. INFORMANT <u>Mrs Angelina Burns, 5215 Cedgate Rd.</u> | |
| 18. <u>445X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerotic and hypertensive cardio-vascular disease</u> | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST, <u>obesity</u> | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>no</u> | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <u>Werner U. Spitz</u> DATE SIGNED <u>12/25/66</u> EXAMINER'S NAME (Type) <u>Werner U. Spitz, M.D.</u> | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23B. DATE <u>12-29-66</u> | | 23C. NAME of CEMETERY or CREMATORY <u>Dulaney Valley</u> | |
| 23D. LOCATION (City, town, or county) (State) <u>Balto., Md.</u> | | 24A. DATE REC'D BY HEALTH DEPT. <u>DEC 27 1966</u> | | 24B. NAME OF REGISTRAR <u>Robert E. Fashy</u> | |
| 24C. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc., 5305 Harford Rd.</u> | | 24D. ADDRESS | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|-----------|---|---|---|--|--|--|---|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 66 12955 | | | | |
| BIRTH NO. 66 12955 | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED (Type or Print) MARGARET ELIZABETH COX | | | | | 2. DATE AND HOUR OF DEATH 12-25-66 10:20 AM M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL 44 | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY Howard Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) ELLICOTT CITY 63-00 D. STREET ADDRESS (If rural, give location) 37 NORMANDY DRIVE | | | | |
| 5. SEX F | 6. RACE C | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | | 8. DATE OF BIRTH 83 11-23-81 | 9. AGE (In years last birthday) 82 83 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | | 10B. KIND OF BUSINESS OR INDUSTRY — | | 11. BIRTHPLACE (State or foreign country) MD. | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME GEORGE BROWN | | | | | 14. MOTHER'S MAIDEN NAME ELIZABETH SHELBY Schelby | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 217-48-8285 | | 17. INFORMANT ADDRESS Raymond E. Cox, 702 Saylor Ct. | | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 19A. DATE OF OPERATION 12-16-66 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ESOPHAGEAL OBST. 20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-10 1966 to 12-25 1966, that (we) last saw the deceased alive on 12-25 1966 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Judith D Gardner M.D. | | | | | 23B. DATE SIGNED 12-25-66 | | | 23C. PHYSICIAN'S NAME (Type) DR JUDITH D GARDNER | |
| 23D. ADDRESS M.D. Union Memorial Hospital | | | | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | |
| 24B. DATE 12-28-66 | | 24C. NAME OF CEMETERY or CREMATORY Parkwood | | | 24D. LOCATION (City, town, or county) Balto., Md. | | | 24E. (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | | 25B. NAME OF REGISTRAR R. E. Taylor | | | 25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc., 5305 Harford Rd. | | | |

down

1942-11-11

66 12956

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 12956

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

William Scott

2. DATE AND HOUR PRONOUNCED DEAD

12/20/66 10:40 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1133 Gilmore St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

?

8. DATE OF BIRTH

?

9. AGE (In years
last birthday)

73

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

219-05-0409

17. INFORMANT

ADDRESS

M's Myrtle Reddick 1133 Gilmore St

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Carcinoma of stomach
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED20A. AUTOPSY? (Yes or No)
NO20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/20/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/23/66

23C. NAME of CEMETERY or CREMATORY

Mt Calvary Cemetery

23D. LOCATION

(City, town, or county)

(State)

A A County Md

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

DEC 27 1966

Adolphus Halstead 1206 W North Ave

PMD-20-005

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | | | BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | | | |
|--|---------------------|---|-------------------------------------|--|-------------------------------|---|--|--|--|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | | 66 12957 | | | |
| 1. NAME OF DECEASED (Type or Print) JAMES ROLAND | | | | 2. DATE AND HOUR OF DEATH 12-27-66 10:20 P.M. | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 35 Church Home & Hospital | | | | A. STATE Md B. COUNTY | | | | | | | |
| (If not in hospital or institution, give street address or location) | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 5-01 | | | | | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 15 N. Exeter St. (31) | | | | | | | |
| 5. SEX M | 6. RACE C | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH 4-6-1902 | 9. AGE (In years lost birth day) 64 | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min. | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) North Carolina | | 12. CITIZEN OF WHAT COUNTRY? U S A | | | | | |
| 13. FATHER'S NAME UNKNOWN | | | | 14. MOTHER'S MAIDEN NAME UNKNOWN | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT (Chart) Mrs Eva Tartt | | ADDRESS 15 N Exeter St | | | | | |
| 18. 587.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Acute Hemolytic Anemia | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | | | INTERVAL BETWEEN ONSET AND DEATH unknown | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Tumor. Embolism, Papilledema | | | | | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-22 19 66 to 12-23 19 66 , that (I) (we) last saw the deceased alive on 12-23 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE Rodelio M. Lim | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-23-66 | | | | | |
| 23C. PHYSICIAN'S NAME (Type) Rodelio M. LIM | | M.D. | | 23D. ADDRESS Church Home & Hosp | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/28/66 | | 24C. NAME of CEMETERY or CREMATORY Mt Calvary Cemetery | | 24D. LOCATION (City, town, or county) (State) A A County Md | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | 25B. NAME OF REGISTRAR John E. ... | | 25C. FUNERAL DIRECTOR A. Halstead | | ADDRESS 1206 W. North Ave. | | | | | |

Thank you very much

17th Street N.W.

North Carolina

(Date) Nov 2nd 1911

Dear Mr. [Name]

Yours truly,
[Signature]

12-22-11

12-22-11

Blind [Name]

Robert M. [Name]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|--|----------------------------|--|---|
| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12958 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | GEORGE RICHARDSON | | 2. DATE AND HOUR OF DEATH 12-20-66 6:20 PM M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHN S HOPKINS HOSPITAL | | A. STATE MARYLAND | | B. COUNTY | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | D. STREET ADDRESS (If rural, give location) 1731 GUILFORD AVE | |
| 5. SEX MALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 6-2-10 | 9. AGE (In years last birthday) 56 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Amelia Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? U S A | | 13. FATHER'S NAME EDWARD RICHARDSON | | 14. MOTHER'S MAIDEN NAME ANN JACKSON | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs Helen Richardson 1731 Guilford Ave | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION CAUSING IT. Diabetes. | | CAUSE OF DEATH M.I. | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/17 1966 to 12/20 1966, that (I) (we) last saw the deceased alive on 12/20 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE W Stan Wilson | | 23B. DATE SIGNED 12/20/66 | |
| 23C. PHYSICIAN'S NAME (Type) W Stan Wilson | | 23D. ADDRESS J.H.H. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/23/66 | | 24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cemetery | |
| 24D. LOCATION (City, town, or county) (State) A A County Md | | 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | 25B. NAME OF REGISTRAR Adolphus Halstead 1206 W North Ave | |
| 25C. FUNERAL DIRECTOR Adolphus Halstead 1206 W North Ave | | 25D. ADDRESS | | | |

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66 12959
BIRTH NO.

66 12959

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

| | | | | | | | |
|--|---------------------------|--|------------------------------|---|---|---|--|
| 1. NAME OF DECEASED (Type or Print) Charles Jones | | | | 2. DATE AND HOUR PRONOUNCED DEAD 12/19/66 8:30 p. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland General Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-05 D. STREET ADDRESS (If rural, give location) 1710 N. Calvert St. | | | |
| 5. SEX male | 6. RACE colored | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) ? | 8. DATE OF BIRTH ? | 9. AGE (In years last birthday) 44 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) ? | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME ? | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. ? | | 17. INFORMANT ADDRESS Mack Jones 1710 N Calvert St | | | |
| 18. CAUSE OF DEATH 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) DUE TO II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Fatty alteration of liver | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE Werner U. Spitz, M.D. | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 12/20/66 | | | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 12/24/66 | | 23C. NAME of CEMETERY or CREMATORY Mt Calvary Cemetery | | 23D. LOCATION (City, town, or county) (State) A A County Md | |
| 24A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | 24B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 24C. FUNERAL DIRECTOR ADDRESS Adolphus Halstead 1206 W North Ave | | | |

1914-15

1915-16

FUNERAL DIRECTOR: IMPORTANT

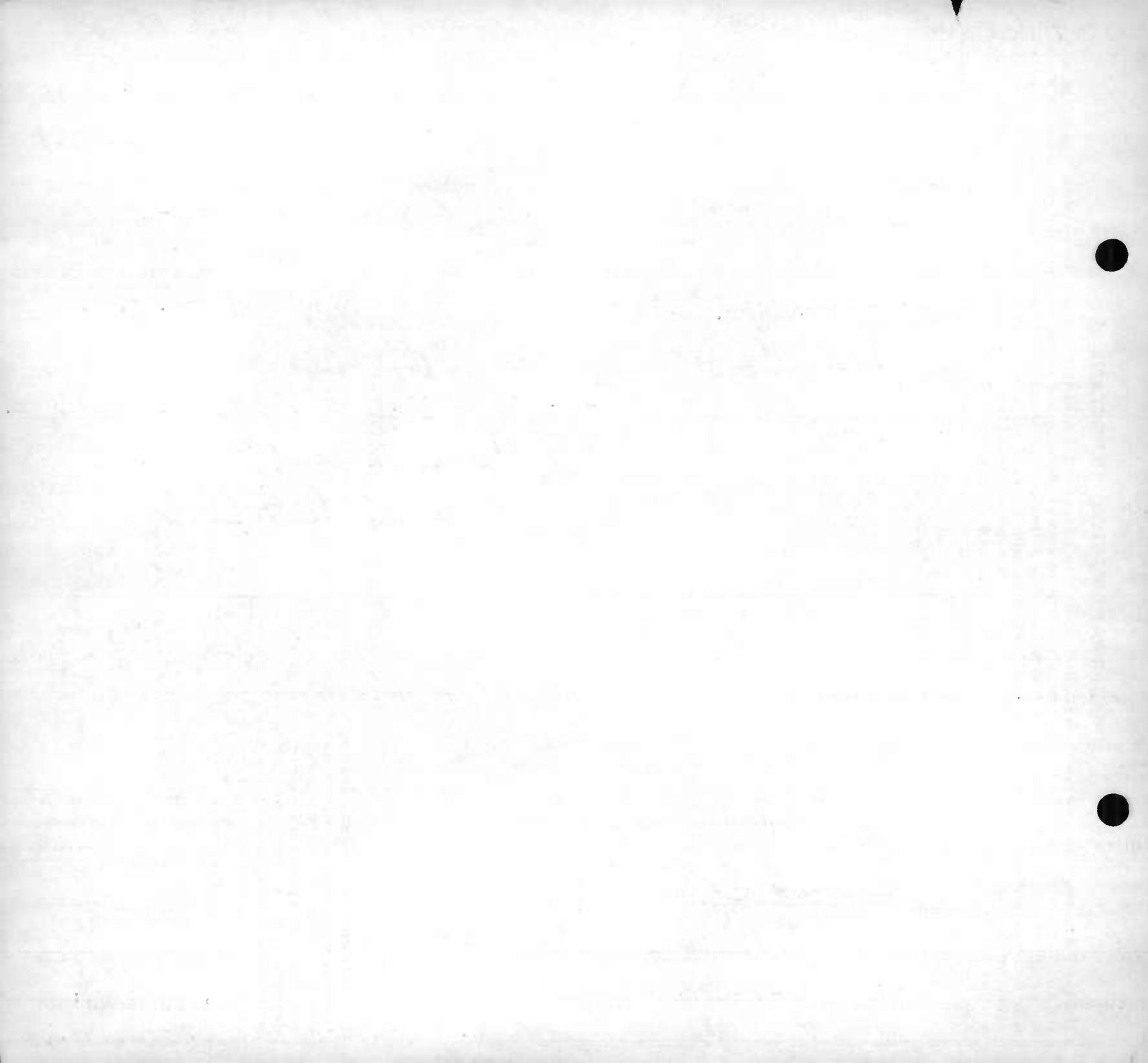
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|-------------------------|---|-------------------------|---|--|--|-------------------------------------|-----------------------------|--|
| BIRTH NO. 66 12960 | | | | | CERTIFICATE OF DEATH | | Registered No. 66 12960 | | |
| 1. NAME OF DECEASED (Type or Print) <i>Dick W. Newcomb.</i> | | | | | 2. DATE AND HOUR OF DEATH <i>12-21-66 8:32 A.M.</i> | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>23-02</i> | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>43 South Baltimore General Hosp</i> | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 21230</i> | | | | |
| D. STREET ADDRESS (If rural, give location) <i>1422 Patapsco St.</i> | | | | | | | | | |
| 5. SEX <i>M.</i> | 6. RACE <i>White</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Separated</i> | | 8. DATE OF BIRTH <i>3-30-07</i> | 9. AGE (in years last birthday) <i>59</i> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY <i>NONE</i> | | 11. BIRTHPLACE (State or foreign country) <i>West Virginia</i> | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| 13. FATHER'S NAME <i>Eldridge Newcomb.</i> | | | | | 14. MOTHER'S M maiden NAME | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | | ADDRESS | |
| 18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Acute Myocardial Infarction</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>YES</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that <i>(H)</i> (this hospital) attended the deceased from <i>11/7</i> 19 <i>66</i> to <i>12/4</i> 19 <i>66</i> , that <i>(H)</i> (we) last saw the deceased alive on <i>12/4</i> 19 <i>66</i> and that in <i>(our)</i> (our) opinion death occurred on the date and hour and from the cause stated above. <i>(H)</i> (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <i>Colen C. Heineitz</i> | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>12/21/66</i> | | |
| 23C. PHYSICIAN'S NAME (Type) <i>COLEN C. HEINEITZ</i> | | | | | 23D. ADDRESS <i>SOUTH BALTIMORE GENERAL HOSPITAL</i> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY <i>Blue Grass</i> | | 24D. LOCATION (City, town, or county) <i>Virginia</i> | | (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 27 1966</i> | | 25B. NAME OF REGISTRAR <i>D. G. E. E. E.</i> | | 25C. FUNERAL DIRECTOR <i>Walter Dabrowski</i> | | ADDRESS <i>1005 Dundalk Ave</i> | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 12961</u> | |
|---|----------------------|---|--|--|--|
| <div style="display: flex; justify-content: space-between;"> BIRTH NO. <u>66 12961</u> CERTIFICATE OF DEATH </div> | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Lillian Julia Schuler</u> | | | 2. DATE AND HOUR OF DEATH <u>12-22-66</u> <u>10:42 A.M.</u> | | |
| 3. PLACE OF DEATH <u>BALTIMORE, MARYLAND</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>22-01</u> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>43 South Baltimore General Hosp.</u> | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore #21230</u> | | |
| (If not in hospital or institution, give street address or location) | | | D. STREET ADDRESS (If rural, give location) <u>208 Warren Ave.</u> | | |
| 5. SEX <u>F.</u> | 6. RACE <u>W.</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widow</u> | 8. DATE OF BIRTH <u>2-4-1885</u> | 9. AGE (In years last birthday) <u>81</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rooming House Oper.</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>None</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | 13. FATHER'S NAME <u>John Heiger</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Marie Schaeffer</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> | | | |
| 16. SOCIAL SECURITY NO. <u>220-32-3111</u> | | 17. INFORMANT ADDRESS <u>William Heiger 1213 S. Hanover St.</u> | | | |
| 18. <u>434.1 I</u> CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cardiac arrest</u> | | | (A) DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Coronary heart failure</u> | | | (B) DUE TO | | |
| (C) _____ | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>YES</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (*) (this hospital) attended the deceased from <u>12-15</u> 19 <u>66</u> to <u>12-22</u> 19 <u>66</u> , that (*) (we) last saw the deceased alive on <u>12-22</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Camilo C. Balacuit</u> M.D. | | | | 23B. DATE SIGNED <u>12-22-66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Camilo C. Balacuit</u> M.D. | | | | 23D. ADDRESS <u>1213 Light St.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12-26-1966</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Landon Park</u> | |
| 24D. LOCATION <u>Baltimore, Md.</u> | | 24E. STATE <u>Md.</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 27 1966</u> | | 25B. NAME OF REGISTRAR <u>G. Howard Strong</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>3207 W. North Ave.</u> | |



S-363

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 66 12962 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12962

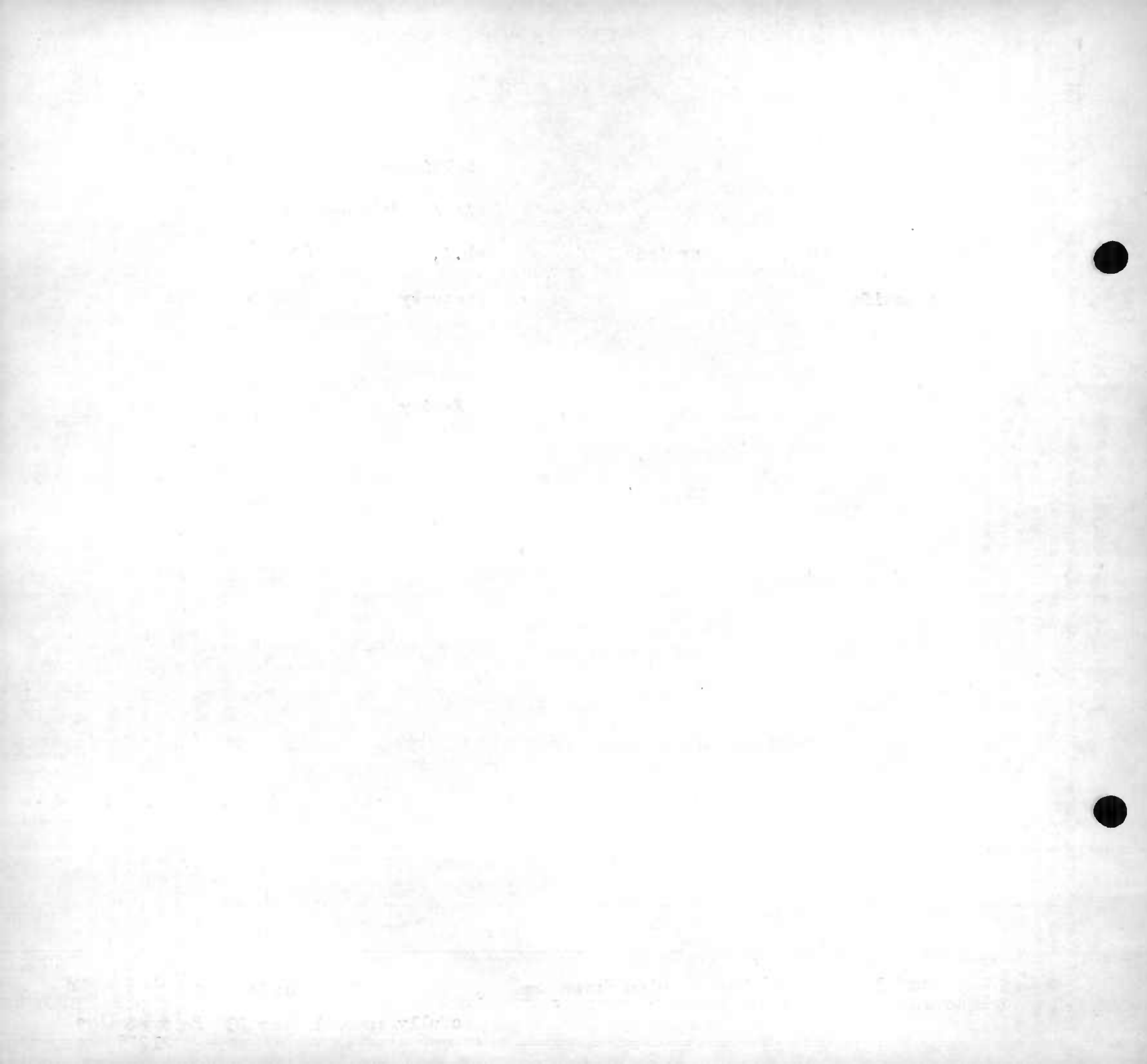
M.E. CASE NO.

| | | | |
|--|---------------------------|---|--|
| 1. NAME OF DECEASED (Type or Print) Herbert Stewart | | 2. DATE AND HOUR PRONOUNCED DEAD 12/23/66 5:40 p. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 City Hospitals | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1219 Dallas St. | |
| 5. SEX male | 6. RACE colored | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH Nov. 17, 1926 |
| 9. AGE (In years lost birthday) 38 | | 10. Under 1 Yr. 11 Under 24 Hrs. Months Days Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HANDY MAN | | 10B. KIND OF BUSINESS OR INDUSTRY DIXIE DINER | |
| 11. BIRTHPLACE (State or foreign country) BALTO., Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME SAMUEL STEWART | | 14. MOTHER'S MAIDEN NAME Virgie Johnson | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES D.S. 1960 | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Virgie Stewart | | ADDRESS 1219 N. DALLAS ST. | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple injuries ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 5900 Blk. Pulaski Hwy. 26-44 | | 21D. TIME OF INJURY (APPROX.) 12 23 66 4:55 p. | |
| 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? pedestrian struck by bus | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Werner U. Spitz EXAMINER'S NAME (Type) | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| DATE SIGNED 12/25/66 | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 23B. DATE 12/29/66 | |
| 23C. NAME OF CEMETERY or CREMATORY Balto. National | | 23D. LOCATION (City, town, or county) (State) D. D. County | |
| 24A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | 24B. NAME OF REGISTRAR Robert E. Johnson | |
| 24C. FUNERAL DIRECTOR Joseph S. Locks | | ADDRESS 1304 N. Central Ave | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

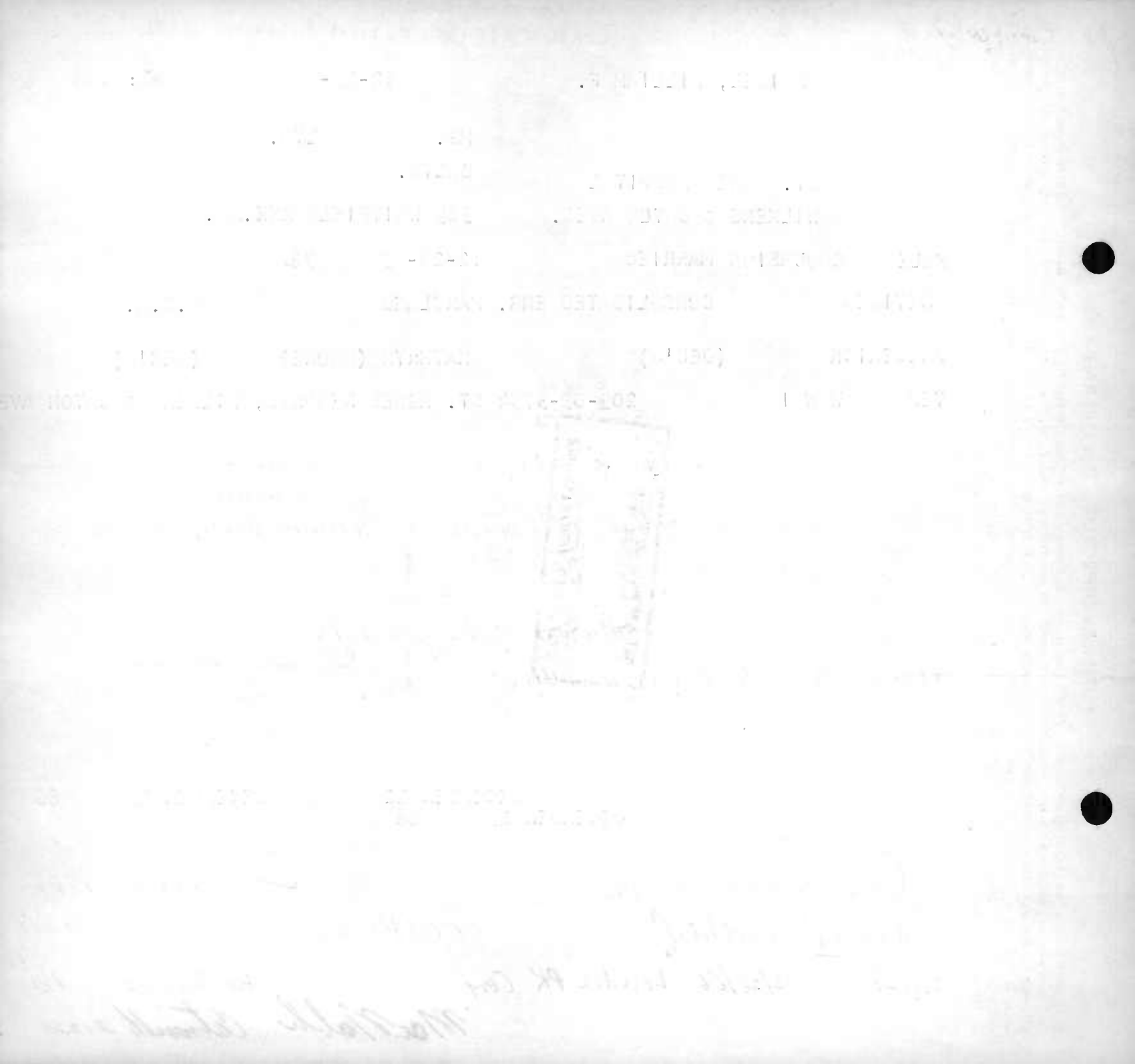
| BIRTH NO. 66 12963 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12963 | |
|---|--|---|--|--|--|--|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | | | <i>Eunice Berry</i> | | <i>12-21-66 6:45 P.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE Md | | B. COUNTY | |
| <i>Mercy Hospital</i> | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | <i>25-05</i> | |
| D. STREET ADDRESS (If rural, give location) | | | | 4404 Fairhaven Ave | | | |
| 5. SEX Female | | 6. RACE Cau | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | | 8. DATE OF BIRTH Feb. 4, 1906 | |
| 9. AGE (In years lost birthday) 60 | | 10. DATE OF BIRTH | | 11. BIRTHPLACE (State or foreign country) Kentucky | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Family | |
| 18. <i>134X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) <i>Cancer of rectum with metastasis</i> DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH ? | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION <i>12/15/66</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Resection of small & large bowel</i> | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>12-4</i> 19 <i>66</i> to <i>12-21</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>12-21</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Hung-Jen Fu</i> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>12/22/66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>HUNG-JEN FU</i> | | | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE <i>12/24/66</i> | | 24C. NAME OF CEMETERY or CREMATORY Glen Haven Cem | | 24D. LOCATION (City, town, or county) (State) Glen Burnie AAco Md | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 27 1966</i> | | 25B. NAME OF REGISTRAR <i>J. E. ...</i> | | 25C. FUNERAL DIRECTOR ADDRESS McCully Funeral Home 237 Patapsco Ave <i>21225</i> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

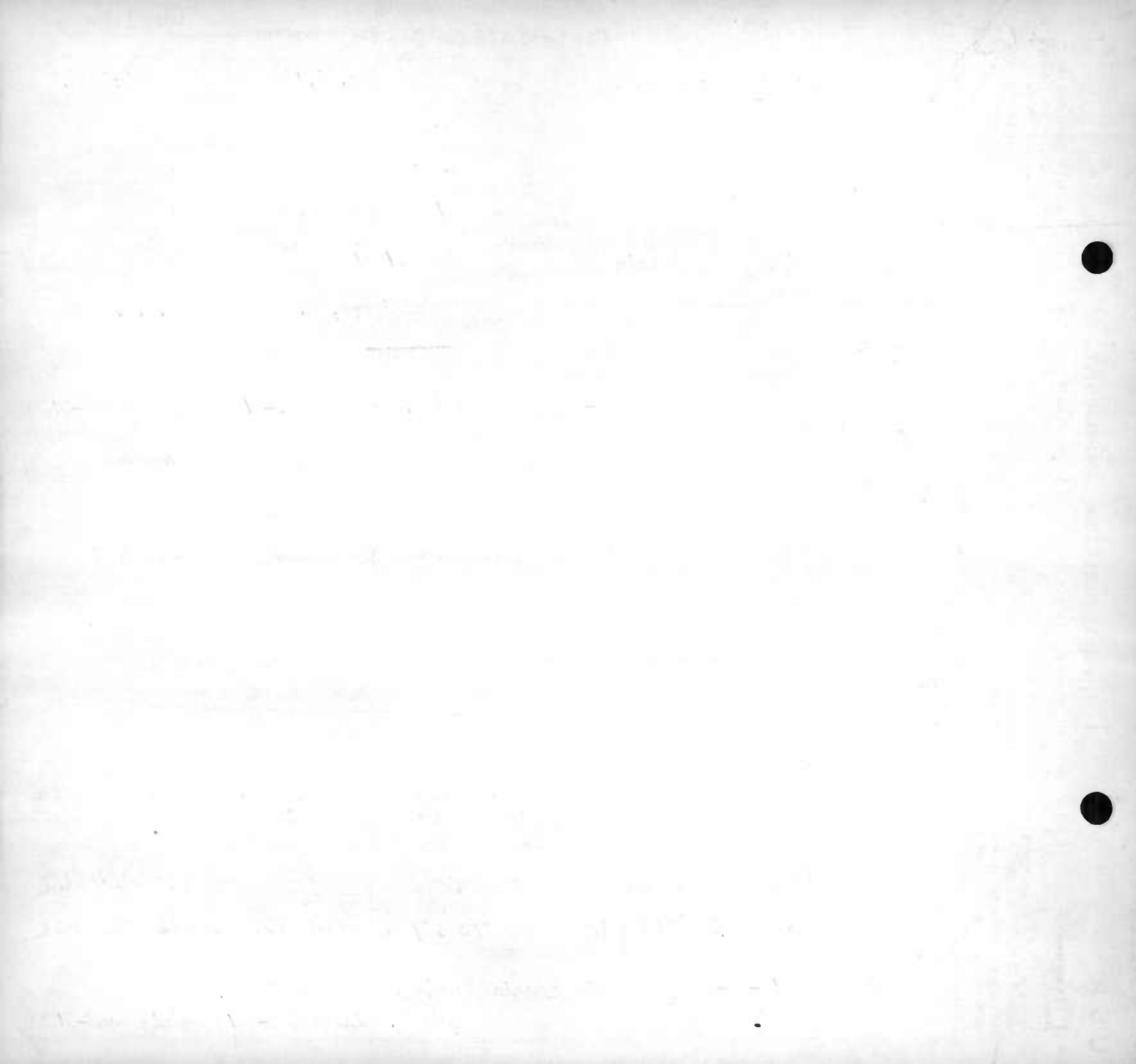
| | | | | | |
|---|-----------|--|------------------|--|---|
| BIRTH NO. 66 12964 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12964 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| MAISEL, WILLIAM F. | | 12-23-66 | | 2:40AM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| 40 ST. AGNES HOSPITAL WILKENS & CATON AVES. | | MD. BALTO. Balto. Co. BALTO. 53-00 | | | |
| D. STREET ADDRESS (If rural, give location) | | 365 WHITFIELD AVE. RD. | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | 10. If Under 1 Yr. Months Days Hours Min. |
| MALE | CAUCASION | MARRIED | 12-24-89 | 76 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| RETIRED | | CONSOLIDATED ENG. | | MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| U.S.A. | | FREDERICK (DEC'D) | | KATHRYN (MOORE) (DEC'D) | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| YES W W I | | 202-09-3754 | | ST. AGNES RECORDS, WILKENS & CATON AVE | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, asthma, etc, it means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | Myocardial Infarction. Hypertension & hypovolemia. (Duodenal) Bleeding Ulcer, 1.50 V. D. | | 2 Hrs. 3-4 Hrs. 24 Hrs. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | of the prostate. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 12-23-66 | | Bleeding duodenal ulcer. | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from DECEMBER 22 19 66 to DECEMBER 23 19 66, that (I) (we) last saw the deceased alive on DECEMBER 23 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | | |
| Adrian Sanchez, MD. | | Dec. 23-1966. | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Adrian Sanchez | | 5503 Knollview Ct, Balto. Md, 21228 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 12/26/66 | | Loudon PK. Cem. | |
| 24D. LOCATION (City, town, or county) (State) | | 24E. DATE REC'D BY HEALTH DEPT. | | 24F. NAME OF REGISTRAR | |
| BALTIMORE MD. | | DEC 27 1966 | | E. E. E. | |
| 24G. FUNERAL DIRECTOR ADDRESS | | 24H. NAME OF REGISTRAR | | 24I. FUNERAL DIRECTOR ADDRESS | |
| Mac Nabb Catonsville 21228 | | E. E. E. | | Mac Nabb Catonsville 21228 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | | | | | |
|--|--|-------------------------|--|--|---|--|--|--|--|---|--|-----------------------------|--|--|---|--|--|--|--|
| BIRTH NO. 66 12965 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 66 12965 | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | | 1. NAME OF DECEASED (Type or Print) <i>Amelia Catherine Cochran</i> | | | | | 2. DATE AND HOUR OF DEATH <i>Dec. 23, 1966</i> <i>8:50 A.</i> M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY | | | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>00 4102 Raspe Avenue</i> | | | | | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | | | | 27-34 | | | | |
| | | | | | | | | | | D. STREET ADDRESS (If rural, give location) <i>4102 Raspe Avenue</i> | | | | | | | | | |
| 5. SEX <i>Female</i> | | 6. RACE <i>White</i> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i> | | 8. DATE OF BIRTH <i>July 29, 1891</i> | | 9. AGE (In years last birthday) <i>75</i> | | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Home Maker</i> | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | | 11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i> | | | | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | | |
| 13. FATHER'S NAME <i>Morris Heagy</i> | | | | | | | | | | 14. MOTHER'S MAIDEN NAME <i>Unknown Hupka</i> | | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. <i>-</i> | | | | | 17. INFORMANT <i>Goff C. Cochran Sr.</i> | | | | | ADDRESS <i>4102 Raspe Avenue-21206</i> | | | | |
| 18. <i>422.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | CAUSE OF DEATH (A) <i>Cerebral Vascular Accident</i> DUE TO (B) <i>Atherosclerotic Cardio</i> DUE TO (C) <i>vascular Disease</i> | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>6 wks.</i> <i>undet</i> | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20A. AUTOPSY? (Yes or No) | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>January</i> 19 <i>66</i> to <i>Dec 23</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>Dec 23</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 23A. SIGNATURE <i>John C. Hyle</i> | | | | | | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | | 23B. DATE SIGNED <i>12-24-66</i> | | | | |
| 23C. PHYSICIAN'S NAME (Type) <i>JOHN C. Hyle</i> | | | | | | | | | | M.D. 23D. ADDRESS <i>7527 Belair Rd Balto 36 Md</i> | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | | | | 24B. DATE <i>12-27-66</i> | | | | | 24C. NAME of CEMETERY or CREMATORY <i>Belair Memorial Gardens</i> | | | | | 24D. LOCATION (City, town, or county) (State) <i>Belair Md.</i> | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 27 1966</i> | | | | | 25B. NAME OF REGISTRAR <i>Robert E. Salvo</i> | | | | | 25C. FUNERAL DIRECTOR <i>John C. Miller Inc</i> | | | | | ADDRESS <i>415 Belair Road-21206</i> | | | | |



K-623

66 12966

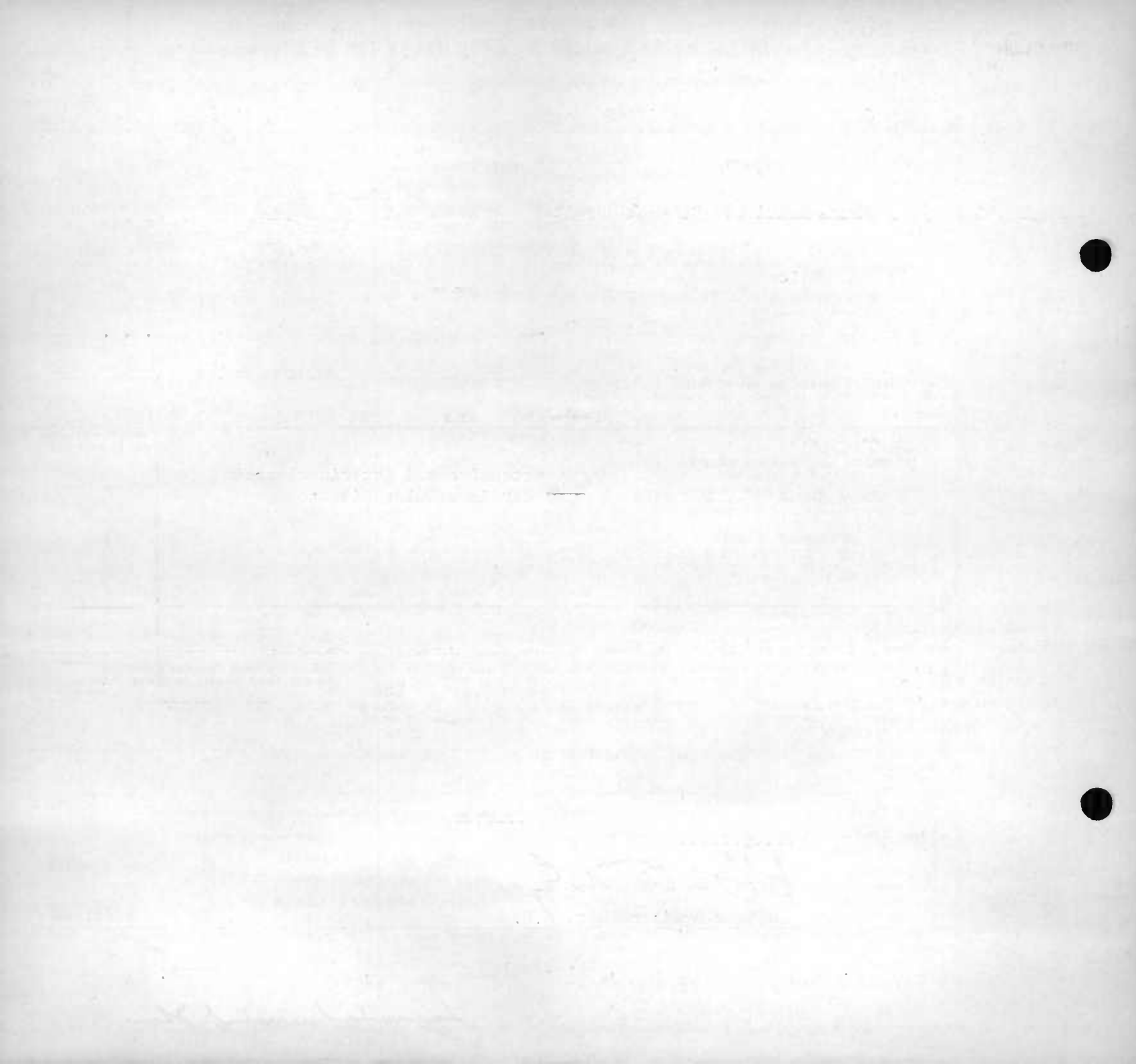
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12966

BIRTH NO.

M.E. CASE NO.

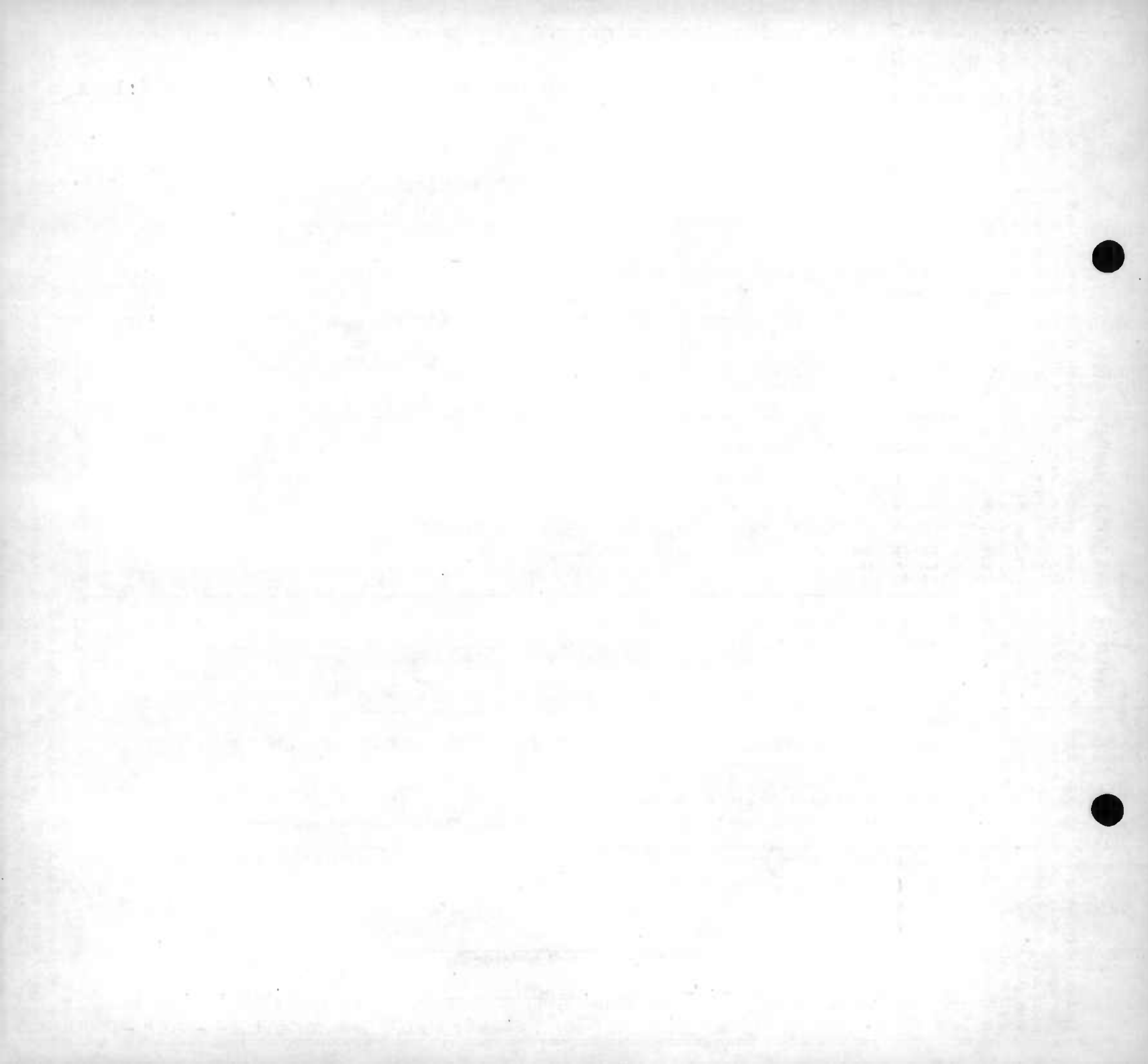
| | | | | | | | |
|---|-------------------------|--|-------------------------------------|--|---|--|----------------------------------|
| 1. NAME OF DECEASED (Type or Print) JOHN KRISTIAN | | | | 2. DATE AND HOUR PRONOUNCED DEAD December 21, 1966 8:15 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 43 South Baltimore General Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-34 D. STREET ADDRESS (If rural, give location) 5422 Bellevista Avenue 21206 | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 9-8-1913 | 9. AGE (In years last birthday) 53 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Erector | | 10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel | | 11. BIRTHPLACE (State or foreign country) Hazleton Penna | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John Kristian | | | | 14. MOTHER'S MAIDEN NAME Thersa Hruka | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown); (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 171-01-3099 | | 17. INFORMANT ADDRESS Mrs Margaret Kristian 5422 BelleVista A | | | |
| 18. CAUSE OF DEATH Hypertensive and Arteriosclerotic Cardiovascular Disease DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Rudiger Breiteneker, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 12-24-1966 | | 23C. NAME of CEMETERY or CREMATORY St. Peter Paul Lutheran Cem. | | 23D. LOCATION (City, town, or county) (State) Hazleton Penna. | |
| 24A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | 24B. NAME OF REGISTRAR E. J. Kelly | | 24C. FUNERAL DIRECTOR ADDRESS Lussan Funeral Home | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 12967 | | | | BALTIMORE HEALTH DEPARTMENT | | Registered No. 66 12967 | |
|---|--|--|--|---|--|--|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| (Type or Print) | | | | Yow LIEU (also Lieu Yow Hawk) | | 12/22/66 5:10 A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | |
| 90 MidTowne Nursing Home (21202) | | | | Maryland (Balto. City.) | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | Baltimore 16-01 | | | |
| D. STREET ADDRESS (If rural, give location) | | | | 1220 N. Fremont St. (21217) | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | |
| Male | | Chinese | | Married | | Abt May-18-1882 84 | |
| 9. AGE (In years last birthday) | | 10. UNDER 1 Yr. Months Days | | 11. UNDER 24 Hrs. Hours Min. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| none | | none | | China | | ? | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Lieu Gam Gong | | | | Lee Shee | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| no | | no | | Yoke Wee Lieu (son) 1220-N-Fremont-St | | | |
| 18. CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | (A) DUE TO | | | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | Cardio Respiratory Failure | | | |
| ANTECEDENT CAUSES | | | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | Impulsive Heart Failing | | | |
| II | | | | (C) DUE TO | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | Gen. Arteriosclerosis | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 0 | | 0 | | 0 | | 0 | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) | |
| 0 | | 0 | | 0 | | 0 | |
| 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from | | 22. I certify that (I) (this hospital) attended the deceased from | |
| While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 0 | | 0 | | 0 | |
| 22. I certify that (I) (this hospital) attended the deceased from | | 22. I certify that (I) (this hospital) attended the deceased from | | 22. I certify that (I) (this hospital) attended the deceased from | | 22. I certify that (I) (this hospital) attended the deceased from | |
| 0 | | 0 | | 0 | | 0 | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | |
| 0 | | 0 | | 0 | | 0 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| burial | | Dec-24-66 | | Lorraine | | Woodlawn, Md. 21207 | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| DEC 27 1966 | | 02-28-66 | | Stewart & Mowen Co | | 108-W-NORTH-21201 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. <u>92324</u> | |
|---|-------------------------|---|--|--|---|--|--|
| BIRTH NO. <u>66 12968</u> | | M.E. CASE NO. <u>213-05-1460 A</u> | | 1. NAME OF DECEASED (Type or Print) <u>CHIEF W. MR. HAYDEN</u> | | 2. DATE AND HOUR OF DEATH <u>Dec. 24, 1966</u> <u>12:20 AM</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) <u>34 BON SECOURS HOSPITAL</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALTIMORE</u> <u>2825 Eastern Ave. 24</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore Md - 1-03</u> D. STREET ADDRESS (If rural, give location) | | | |
| 5. SEX <u>MALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>W</u> | 8. DATE OF BIRTH <u>5-11-92</u> | 9. AGE (In years last birthday) <u>74</u> | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>maintenace</u> | | |
| 11. BIRTHPLACE (State or foreign country) <u>Westminister Md -</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | | | |
| 13. FATHER'S NAME <u>Howard G. Chew</u> | | | 14. MOTHER'S MAIDEN NAME <u>Ada May Houch</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> | | | 16. SOCIAL SECURITY NO. <u>213-05-1460</u> | | 17. INFORMANT <u>DAUGHTER MRS. BEVERLY DORSEY</u> | | |
| 18. <u>181.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Tibialis pericarditis</u> | | | CAUSE OF DEATH (A) <u>Adrenal insufficiency</u> DUE TO (B) <u>Melanotic carcinoma</u> DUE TO (C) <u>Ca. urinary bladder</u> | | ADDRESS <u>MONROEVILLE, OHIO.</u> INTERVAL BETWEEN ONSET AND DEATH <u>about 24 months</u> | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>yes</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Dec. 21, 1966</u> to <u>Dec. 24, 1966</u> , that (I) <u>we</u> lost saw the deceased alive on <u>Dec. 24, 1966</u> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We) (did)</u> (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Dong Sup Cha</u> M.D. | | | | 23B. DATE SIGNED <u>Dec. 24, 1966</u> | | 23C. PHYSICIAN'S NAME (Type) <u>DONG SUP CHA</u> M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>12/28/66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>BETHAEL CEM.</u> | | 24D. LOCATION (City, town, or county) (State) <u>BETHAEL-CARROLL, MD</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 27 1966</u> | | 25B. NAME OF REGISTRAR <u>R. E. Tolson</u> | | 25C. FUNERAL DIRECTOR <u>James G. Saffell</u> | | ADDRESS <u>WESTMINSTER MD</u> | |

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5-543

| BIRTH NO. 66 12969 | | BALTIMORE CITY HEALTH DEPARTMENT | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12969 | |
|--|------------------|---|--|--|--|
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) William J. Smallwood | | | 2. DATE AND HOUR PRONOUNCED DEAD 12/25/66 1:57 a. M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 43 South Baltimore General | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2 W. Heath St. 3715 St. Victor St | | |
| 5. SEX male | 6. RACE white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 4 14 1930 | 9. AGE (In years last birthday) 36 | If Under 1 Yr. II Under 24 Hrs. Months, Days, Hours, Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Receiving Clerk | | 10B. KIND OF BUSINESS OR INDUSTRY Whiskey Warehouse | | 11. BIRTHPLACE (State or foreign country) Balto. Md. | |
| 13. FATHER'S NAME Philip E. Smallwood | | | 12. CITIZEN OF WHAT COUNTRY? U S A | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes | | | 14. MOTHER'S MAIDEN NAME Elizabeth F. Stummer | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT Mrs. Joan J. Smallwood | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute bronchopneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerotic heart disease; acute ethylism | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 12/25/66 | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 12 29 1966 | | 23C. NAME of CEMETERY or CREMATORY Cedar Hill | |
| 24A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | 24B. NAME OF REGISTRAR Robert E. Taylor | | 24C. FUNERAL DIRECTOR Mc Cully | |
| | | | | 24D. LOCATION (City, town, or county) (State) Brooklyn, A, A. Co. Md. ADDRESS 130 E. Fort Ave | |

FORG

FUNERAL DIRECTOR: IMPORTANT

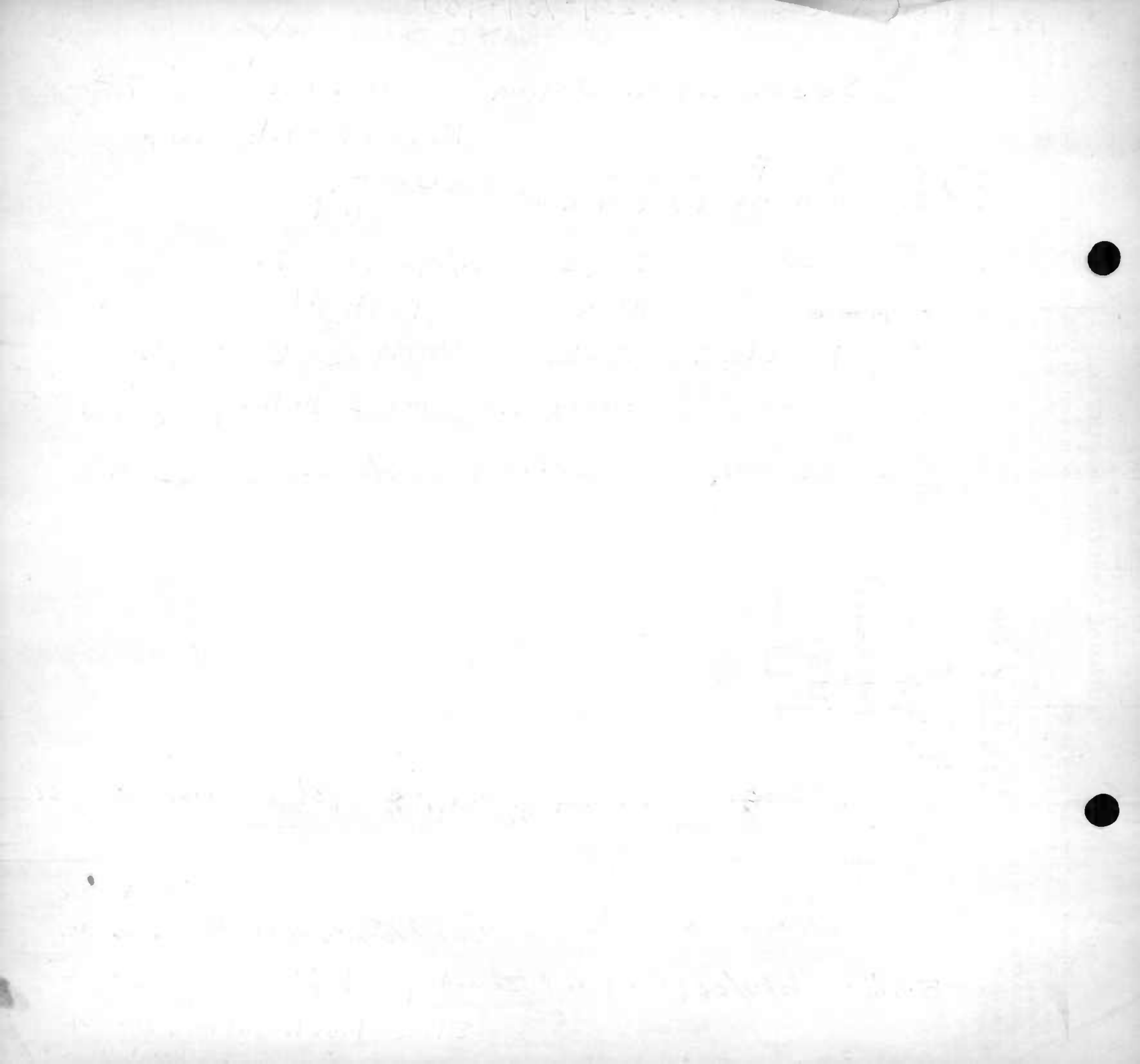
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 12970 | | | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 12970 | |
|---|---------------------|---|------------------------------------|--|---|--|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) <i>Violet Callahan</i> | | 2. DATE AND HOUR OF DEATH <i>12-21-66 9:30 P.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>35 Church Home & Hospital</i> | | (If not in hospital or institution, give street address or location) | | A. STATE <i>Maryland</i> | | B. COUNTY <i>X</i> | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | <i>3-02</i> | |
| | | | | D. STREET ADDRESS (If rural, give location) <i>911 E. Lombard St.</i> | | | |
| 5. SEX <i>F</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>M</i> | 8. DATE OF BIRTH <i>6-23-13</i> | 9. AGE (In years last birthday) <i>43</i> | If Under 1 Yr. Months: Days: Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Georgia</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> |
| 13. FATHER'S NAME <i>Jim Darr</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Pate Ann Shoemaker</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Ben Callahan</i> | | |
| | | | | | ADDRESS | | |
| 18. <i>381.01</i> | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | | | (A) DUE TO <i>Hepatic insuffic.</i> | | <i>unknown</i> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO <i>Portal Embolism</i> | | <i>unknown</i> | |
| | | | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | <i>Bleeding Esoph. Varices</i> | | <i>unknown</i> | |
| 19A. DATE OF OPERATION <i>12-</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Portal Cirrhosis</i> | | 20A. AUTOPSY? (Yes or No) <i>Yes</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>12-4</i> 19 <i>66</i> to <i>Dec. 21</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>12-21</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>asstent</i> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>12-21-66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Dr. M. Tan</i> | | | | 23D. ADDRESS <i>Church Home & Hospital</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12/27/66</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>West Hill Cemetery</i> | | 24D. LOCATION (City, town, or county) (State) <i>Dalton, Georgia</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 27 1966</i> | | 25B. NAME OF REGISTRAR <i>R. E. Callahan</i> | | 25C. FUNERAL DIRECTOR <i>JOHN F. DENNY, INC. 715 Light St.</i> | | | |

FUNERAL DIRECTOR: IMPORTANT

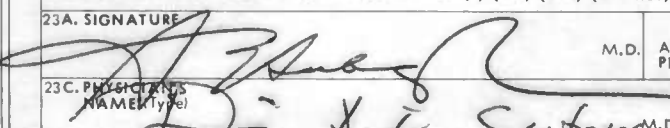
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | 66 12971 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | | 66 12971 | |
|---|--|--|--|---|--|--|--|---|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) <u>Seebo, Laura Virginia</u> | | | | | |
| 2. DATE AND HOUR OF DEATH <u>12-16-1966</u> <u>7¹⁰ am</u> M. | | | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>90 Ashburton House Inc</u> <u>3520 W. Hilton Rd. Balto 15 Md</u> | | | | | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Rosewood State Hosp Balto Co.</u> B. COUNTY <u>Orange Mills 53-00</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) D. STREET ADDRESS (If rural, give location) <u>md</u> | | | | 5. SEX <u>F</u> | | 6. RACE <u>W</u> | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Single</u> | |
| 8. DATE OF BIRTH <u>12/12/1890</u> | | 9. AGE (In years last birthday) <u>76</u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>None</u> | | 11. BIRTHPLACE (State or foreign country) <u>Balto Md</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>August Charles Seebo</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Caroline E Snyder</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>None</u> | | | | 16. SOCIAL SECURITY NO. <u>218-54-0368</u> | | 17. INFORMANT <u>Mrs D Miller - Social Service</u> ADDRESS <u>Rosewood</u> | | | |
| 18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Coronary occlusion</u> DUE TO <u>10 min</u> | | | | 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | 21. MEDICAL CERTIFICATION | | | | | |
| 21A. DATE OF OPERATION <u>12-3-66</u> | | 21B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, lecture, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>Aug 24</u> 19 <u>66</u> to <u>Dec 16</u> 19 <u>66</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>Dec 14</u> 19 <u>66</u> and that in <u>(my house)</u> applan death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> <u>(did)</u> (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>Abraham B. Hurwitz</u> M.D. | | | | 23B. DATE SIGNED <u>Dec. 14, 1966</u> | | | | 23C. PHYSICIAN'S NAME (Type) <u>ABRAHAM B. HURWITZ</u> | |
| 23D. ADDRESS <u>7501 Liberty Road, Baltimore, Md.</u> | | | | 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | | | | |
| 24B. DATE <u>12/21/66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Rosewood Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>on Rosewood property beside St Thomas Church</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 21 1966</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Johnson</u> | | 25C. FUNERAL DIRECTOR <u>Orange Mills</u> <u>Eline + Son Funeral Home</u> ADDRESS <u>man st</u> <u>Rosewood Md</u> | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|--|---|--|--|
| BIRTH NO. 66 12972 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12972 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) DELMA ROBERTS | | | 2. DATE AND HOUR OF DEATH 12-22-66 11:07 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHAURCH HOME AND HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 601 D. STREET ADDRESS (If rural, give location) 439 N. LINWOOD AVE. | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 11-23-86 | 9. AGE (In years last birthday) 80 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Md. | |
| 13. FATHER'S NAME Wm. MIDDLETON | | | 14. MOTHER'S MAIDEN NAME Ella HIRSCH | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Elizabeth Burgoyne - 439 N. Linwood | |
| 18. 352X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CUA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. THROMBOSIS | | | INTERVAL BETWEEN ONSET AND DEATH DAYS DAYS | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-3 19 66 to 12-22 19 66 , that (I) (we) last saw the deceased alive on 12-22 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE  | | | 23B. DATE SIGNED 12-22-66 | | |
| 23C. PHYSICIAN'S NAME (Type) Dr. A. E. Sutones | | | 23D. ADDRESS Church Home & Hosp | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-26-66 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery | |
| 24D. LOCATION Baltimore, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | 25B. NAME OF REGISTRAR Robert E. Selinger | | 25C. FUNERAL DIRECTOR John C. Miller Inc-6415 Belair Rd.-21206 | |

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BATTLES

CHURCH HOME AND HOSPITAL

11-22-86 80

11-2-86

MA

HOME WATER

HIPSON

MIDDLETON

PAID

CVA

PAID

THROMBOSIS

12-02 86

12-02 86

12-02 86

12-02 86

General Home Affairs

Dr. X. E. Sutton Jr.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|---------------------|---|---|------------------------------------|--|--|-------------------------|--|--|
| BIRTH NO. 66 12973 | | | | | CERTIFICATE OF DEATH | | Registered No. 66 12973 | | |
| 1. NAME OF DECEASED (Type or Print) <u>Flynn, Matthew S.</u> | | | | | 2. DATE AND HOUR OF DEATH <u>12/25/66</u> <u>8:55 A.M.</u> | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND <u>Sinai Hospital of Baltimore</u> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>42</u> | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Balt. Co.</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> <u>53-00</u> D. STREET ADDRESS (If rural, give location) <u>813 Templecliff Rd.</u> | | | | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>(Never married) Single</u> | | 8. DATE OF BIRTH <u>2/23/94</u> | 9. AGE (In years last birthday) <u>(72) 73</u> | 10. Under 1 Yr. Months: Days: Hours: Min. | | 11. Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Assembly Line Worker</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Iron Bed Mfg.</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u> | | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>Matthew Flynn</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Mary C. Smith</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | 16. SOCIAL SECURITY NO. <u>212-20-5495</u> | | 17. INFORMANT ADDRESS <u>Mrs. Margaret Hook, 813 Templecliff Road.</u> | | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial Infarction</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 hour</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASCVD</u> <u>Unknown</u> | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12/25/66</u> <u>6:30 AM</u> to <u>12/25</u> <u>8:55 AM</u> that (I) (we) lost saw the deceased alive on <u>12/25</u> <u>1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>W. Creplinski</u> | | | | | M.D. Attending <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED <u>12/25/66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>William Creplinski</u> | | | | | 23D. ADDRESS <u>Sinai Hospital of Baltimore</u> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | | 24B. DATE <u>12/29/66</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Cathedral Cemetery</u> | | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 27 1966</u> | | | 25B. NAME OF REGISTRAR <u>Edna E. ...</u> | | | 25C. FUNERAL DIRECTOR ADDRESS <u>B. Vernon ... 4611 Park Heights Ave.</u> | | | |

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M-435

66 12974

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

66 12974

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

THOMAS

MILTON

2. DATE AND HOUR PRONOUNCED DEAD

December 21, 1966

4:30 P

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

31 Baltimore City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Michigan

B. COUNTY Oakland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Walled Lake

D. STREET ADDRESS (If rural, give location)

1720 Big Trail

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Aug. 17, 1922

9. AGE (In years
last birthday)

44

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Pilot

10B. KIND OF BUSINESS OR INDUSTRY

General Motors

11. BIRTHPLACE (State or foreign country)

California

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Thomas Milton

14. MOTHER'S MAIDEN NAME

Eleanor Giantvalley

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown. If yes, give war or dates of service)

Yes

World War II

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Nixon Funeral Chapel Lincoln Pk. Michigan

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic heart disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/22/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Cremation

23B. DATE

12/23/66

23C. NAME of CEMETERY or CREMATORY

Woodmere Crematory

23D. LOCATION

(City, town, or county)

Lincoln Park, Michigan

(State)

24A. DATE REC'D BY HEALTH DEPT.

DEC 27 1966

24B. NAME OF REGISTRAR

Robert E. Johnson

24C. FUNERAL DIRECTOR

James M. Fields - 3300 W. Belvedere Ave
Baltimore, Md.

ADDRESS

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14-18-41

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|--|------------------|--|---------------------------------------|
| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12975 | |
| BIRTH NO. 66 12975 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) MAGALIS, PEARL C | | DECEMBER 23, 1966 10:12P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL CATON AND WILKENS AVENUES BALTIMORE, MD. 21229 | | A. STATE B. COUNTY MARYLAND 21229 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1045 MAIDEN CHOICE LANE, APT. 6 | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 11-13-93 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY NONE | 9. AGE (In years lost birthday) 73 |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME JOHN W. DEAN | | 14. MOTHER'S MAIDEN NAME SMITH HOUSE | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Mr. Amos C. Magalis, 1045 Maiden Choice Lane | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) <i>Acute myocardial infarction</i> DUE TO (B) DUE TO (C) DUE TO | |
| INTERVAL BETWEEN ONSET AND DEATH | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (X) (this hospital) attended the deceased from DECEMBER 20, 1966 to DECEMBER 22, 1966, that (X) (we) last saw the deceased alive on DECEMBER 22, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death. | | | |
| 23A. SIGNATURE <i>S. Korbuly</i> | | 23B. DATE SIGNED 12/23/66 | |
| 23C. PHYSICIAN'S NAME (Type) S. KORBULY | | 23D. ADDRESS ST. AGNES HOSPITAL-CATON & WILKENS AVES | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-28-66 | |
| 24C. NAME of CEMETERY or CREMATORY Baltimore National Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | 25B. NAME OF REGISTRAR <i>Robert E. Hubbard</i> | |
| 25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | ADDRESS | |

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BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED
(Type or Print)

IRVING

PARKINSON

2. DATE AND HOUR PRONOUNCED DEAD

December 21, 1966

7:00 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

37 Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

203 W. Franklin Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

SINGLE

8. DATE OF BIRTH

July 10, 1890

9. AGE (In years
last birthday)

XX 76

10. Under 1 Yr. 11 Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

PAINTER

10B. KIND OF BUSINESS OR INDUSTRY

RETIRED

11. BIRTHPLACE (State or foreign country)

Brooklyn, N.Y.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Parkinson

14. MOTHER'S MAIDEN NAME

Georgianna Irving

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

95-28 - 105th Street
Mrs. Helen Frank Ozone Park, New York 11416

18. 420.0 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Heart Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
12/22/6623A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12-26-1966

23C. NAME of CEMETERY or CREMATORY

Long Island National Cemetery, Pinelawn, Long Island N.Y.

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

DEC 27 1966

Howard H. Hubbard, 4107 Wilkens Ave. 21229

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200-240-1111

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|---------------------|---|------------------------------------|--|----------------------------|--|--|
| BIRTH NO. 66 12977 | | CERTIFICATE OF DEATH | | Baltimore City Health Department | | Registered No. 66 12977 | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) EDWARD ECHICKSON | | | | 12-21-66 9:10 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 91 Levindale | | (If not in hospital or institution, give street address or location) | | A. STATE MD B. COUNTY BALTIMORE | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 27-17 | | | |
| | | | | D. STREET ADDRESS (If rural, give location) LEVINDALE HEBREW HOME & INFIRMARY | | Belvedere at Greenspring | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married | B. DATE OF BIRTH 12-3-03 | 9. AGE (In years lost birthday) 63 | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper | | 10B. KIND OF BUSINESS OR INDUSTRY — | | 11. BIRTHPLACE (State or foreign country) Baltimore | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Joseph | | | | 14. MOTHER'S MAIDEN NAME Ida Joelson | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Benjamin Echickson | | ADDRESS 6310 Greenspring Ave Baltimore 21219 | |
| 18. 666X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Pulmonary Embolism | | | | CAUSE OF DEATH (A) Acute Pulmonary Embolism DUE TO | | INTERVAL BETWEEN ONSET AND DEATH few minutes | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Phlebotrombosis | | | | (B) Phlebotrombosis DUE TO | | 1 1/2 months | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 11-30-1962 to 12-21-1966 , that (1) (we) last saw the deceased alive on 12-21-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Jose Ardaiz | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-21-66 | |
| 23C. PHYSICIAN'S NAME (Type) Jose ARDAIZ | | | | 23D. ADDRESS M.D. 5912 Cross Country Blvd. Baltimore Md. 21215 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/22/66 | | 24C. NAME of CEMETERY or CREMATORY Rosedale | | 24D. LOCATION (City, town, or county) (State) Balto Md | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | 25B. NAME OF REGISTRAR Benjamin Echickson | | 25C. FUNERAL DIRECTOR Sylvan S. Lewis & Son | | ADDRESS 3319 N. Olympia | |

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DATE: 11-11-11

REMARKS: HAD A GOOD TIME

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NAME: MAMAL

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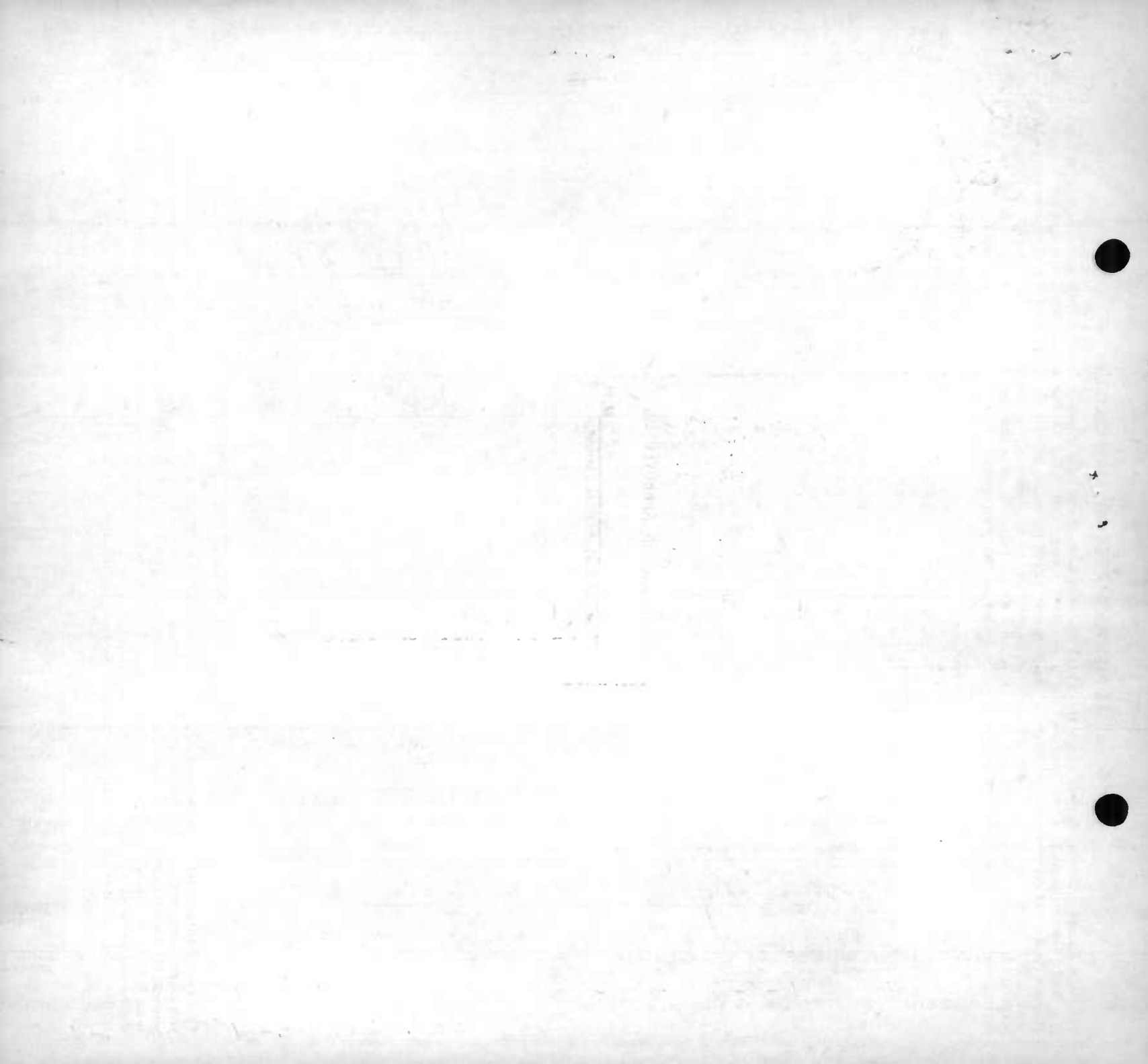
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FUNERAL DIRECTOR: IMPORTANT

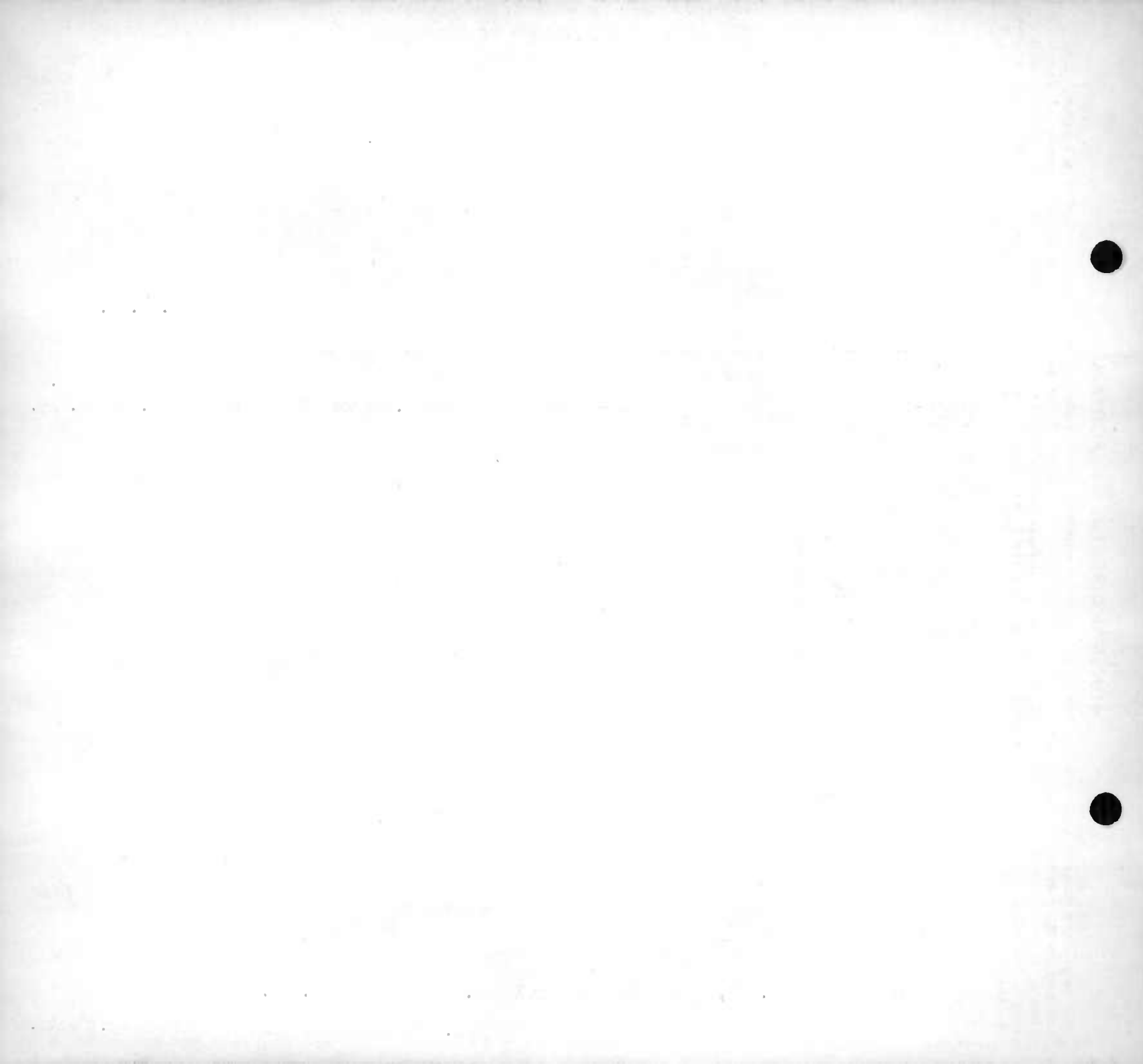
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 12978 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12978 | |
|--|---------------------|--|---------------------------------------|---|--|---|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) CHARLES S. CHESTER | | | | 2. DATE AND HOUR OF DEATH 12/18/66 1145 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTO. MD. C. CITY OR TOWN (If outside city limits, write RURAL and give township) 10-01 D. STREET ADDRESS (If rural, give location) 1200 Valley Street | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WID. | 8. DATE OF BIRTH 12/22/1882 | 9. AGE (In years lost birthday) 83 | If Under 1 Yr. Months: Days: Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) BALTO. MD. | | 12. CITIZEN OF WHAT COUNTRY? USA. | |
| 13. FATHER'S NAME Unknown | | | | 14. MOTHER'S MAIDEN NAME MARY WEBER | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. 21-18-1105 | | 17. INFORMANT ADDRESS Viola Clark - 4214 Belmar Ave. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) PROBABLE ACUTE MI | | | | CAUSE OF DEATH (A) PROBABLE ACUTE MI (B) ASCVD (C) | | INTERVAL BETWEEN ONSET AND DEATH RECENT | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | FRACTURE OF LEFT CLAVICLE | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | SUSPECTED MEDICAL | | | |
| 19A. DATE OF OPERATION 12/13/66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED SUSPECTED MEDICAL | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NURSING HOME | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) LITTLESISTERS OF POOR - NURSING HOME | | 21F. HOW DID INJURY OCCUR? PT. FELL. | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 11-11-66 and 12/3/66 | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | | | | |
| 22. I certify that (X) (this hospital) attended the deceased from 12/13 19 66 to 12/18 19 66 , that (I) (we) last saw the deceased alive on 12/18 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE B. Ominsky M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED 12/19/66 | | | |
| 23C. PHYSICIAN'S NAME (Type) BARRY Ominsky | | 23D. ADDRESS MERCY HOSPITAL | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-22-66 | | 24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS John C. Miller Inc. - 6415 Belair Rd. - 21206 | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|--|-------------------------|--|--|--|---|
| BIRTH NO. 66 12979 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 12979 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <i>Mrs Anna J Doyle</i> | | | 2. DATE AND HOUR OF DEATH <i>12-23-66 11 15 AM M.</i> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>34 Bon Secours Hospital</i> | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland.</i> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balto - 25-41</i> D. STREET ADDRESS (If rural, give location) <i>3717 Clarenell Rd Balto 29 Md.</i> | | |
| 5. SEX <i>Female</i> | 6. RACE <i>White</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed -</i> | 8. DATE OF BIRTH <i>6-30-90</i> | 9. AGE (In years last birthday) <i>76</i> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Wife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) <i>Balto Md</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i> |
| 13. FATHER'S NAME <i>William. Hochler</i> | | | 14. MOTHER'S MAIDEN NAME <i>Eliz. Smith.</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>214-26-6344-A</i> | 17. INFORMANT ADDRESS <i>Md. Melvin T. Doyle 3717 Clarenell Rd. Balto. 29.</i> | | |
| 18. <i>422.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) DUE TO <i>Myocardial disease</i> (B) DUE TO <i>Arteriosclerotic vascular disease</i> (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH <i>-</i> |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>NO</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <i>N</i> (this hospital) attended the deceased from <i>12-8-1966</i> to <i>12-23-1966</i> , that <i>N</i> (we) last saw the deceased alive on <i>12-23-66</i> and that in <i>my</i> (our) opinion death occurred on the date and hour and from the causes stated above. <i>N</i> (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Blanco & Cuffia</i> | | | | 23B. DATE SIGNED <i>12-23-66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Blanco Luisa CUFFIA</i> | | | | 23D. ADDRESS <i>B.S.H.</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>Dec. 27, 1966</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral Cem.</i> | |
| 24D. LOCATION <i>Balto. Md.</i> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR <i>G. Truman Schwab</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>3512 Frederick Ave. Balto. Md.</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 12980 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 66 12980 | |
|--|------------------|--|---------------------------------|---|----------------------------|--|-----------------------------|----------------------------------|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) <i>Weilbreuner, Estelle BETKEY</i> | | 2. DATE AND HOUR OF DEATH <i>12-25-1966</i> | | <i>2:20 P.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE <i>Maryland</i> | | B. COUNTY <i>BALTIMORE</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | D. STREET ADDRESS (If rural, give location) | | | |
| <i>36 Franklin Square Hosp.</i> | | | | <i>DUNDALK 21222</i> | | <i>009 Calgate Ave. 2253-00</i> | | | |
| 5. SEX <i>F</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>LEGAL SEPARATION</i> | 8. DATE OF BIRTH <i>7/23/95</i> | 9. AGE (In years last birthday) <i>71</i> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| <i>SALES WOMAN</i> | | <i>RETAIL STORE</i> | | <i>MARYLAND</i> | | <i>U.S.A.</i> | | | |
| 13. FATHER'S NAME <i>Betty, Frank</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Flora Saunders</i> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i> | | 16. SOCIAL SECURITY NO. <i>215-32-6900</i> | | 17. INFORMANT <i>RICHARD P. WISCHHUSEN</i> | | ADDRESS <i>210 ST. HELENA DUNDALK, Md.</i> | | | |
| 18. <i>420.1</i> | | | | CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | (A) <i>Ventricular Fibrillation</i> | | | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | | (B) <i>Myocardial Infarction</i> | | | | | |
| ANTECEDENT CAUSES | | | | (C) <i>Anteroseptal Heart Disease</i> | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | |
| II | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>11/14/66</i> to <i>12/25/66</i> that (I) (we) last saw the deceased alive on <i>12/25/66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <i>[Signature]</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED <i>12-25-66</i> | | | | | |
| 23C. PHYSICIAN'S NAME (Type) <i>NEVITA SUAREZ</i> M.D. | | | | 23D. ADDRESS <i>Franklin Square Hosp.</i> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 24B. DATE <i>12/29/66</i> | | 24C. NAME of CEMETERY or CREMATORY <i>DAK LAWN</i> | | 24D. LOCATION (City, town, or county) (State) <i>BALTO. CO. Md.</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 27 1966</i> | | 25B. NAME OF REGISTRAR <i>[Signature]</i> | | 25C. FUNERAL DIRECTOR <i>[Signature]</i> | | ADDRESS <i>Dundalk, Md.</i> | | | |

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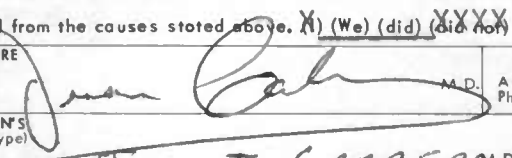
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 12981 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12981 | |
|--|-------------------------|--|-----------------------------------|---|--|---|--|
| M.E. CASE NO. 66 12981 | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Charlie Phillips</i> | | | | 2. DATE AND HOUR OF DEATH <i>12/15/1966 6:15 P.M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>33 THE JOHNS HOPKINS HOSPITAL</i> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE 4-01</i> D. STREET ADDRESS (If rural, give location) <i>700 E. BALTIMORE ST</i> | | | |
| 5. SEX <i>MALE</i> | 6. RACE <i>WHITE</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>SINGLE</i> | 8. DATE OF BIRTH <i>8-7-07</i> | 9. AGE (In years last birthday) <i>59</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Night Clerk</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Hotel</i> | | 11. BIRTHPLACE (State or foreign country) <i>West Virginia</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>JOHN PHILLIPS</i> | | | | 14. MOTHER'S MAIDEN NAME <i>HENRIETTA WELCH</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <i>Miss Agnes Phillips, Morgantown, W. Va.</i> | | | |
| 18. <i>433.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <i>Cardiac arrest</i> | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) DUE TO (B) DUE TO (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Septic embolus, ? gram neg. sepsis</i> | | | | | | | |
| 19A. DATE OF OPERATION <i>2/1</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>YES</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>12/13</i> 19 <i>66</i> to <i>12/19</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>12/19</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Kenneth L. Brigham</i> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>12/19</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Kenneth L. Brigham</i> | | | | 23D. ADDRESS <i>Johns Hopkins Hospital</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial-Remo</i> | | 24B. DATE <i>12/23/66</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Bev. Hills Mem. Gardens</i> | | 24D. LOCATION (City, town, or county) (State) <i>Morgantown, West Virginia</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 27 1966</i> | | 25B. NAME OF REGISTRAR <i>Robert E. ...</i> | | 25C. FUNERAL DIRECTOR <i>Robert E. ...</i> | | ADDRESS <i>Robert E. ...</i> | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 12982</u> | |
|--|------------------------------|--|---|--|--|
| BIRTH NO. <u>66 12982</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) WILLIAM H BURGESS | | 2. DATE AND HOUR OF DEATH 12 25 66 10:30 A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL 40 | | A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 29 D. STREET ADDRESS (If rural, give location) 622 QUEENSGATE RD | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED | 8. DATE OF BIRTH 9 28 97 | 9. AGE (In years last birthday) 69 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Truck driver | | 10B. KIND OF BUSINESS OR INDUSTRY George's Transportation | | 11. BIRTHPLACE (State or foreign country) MD | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Late - Harry Burgess | | | 14. MOTHER'S MAIDEN NAME MARGARET | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ST AGNES HOSP RECORDS WILKENS & CATON Stuart Bailey-622 Queensgate Rd, BALTO 29 MD | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 260X1 | | CAUSE OF DEATH (A) DUE TO CEREBRO-VASCULAR ACCIDENT (B) DUE TO DIABETES MELLITUS - ASCVD (C) DUE TO PNEUMONIA ? | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12 19 66 to 12 25 66 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12 25 66 and that in (my) <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (did not) view the body after death. | | | | | |
| 23A. SIGNATURE  JUAN J. CABRERA M.D. | | | | 23B. DATE SIGNED 12 25 66 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS ST AGNES HOSP WILKENS & CATON BALTO 29 MD | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 12-20-66 | 24C. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem. | | 24D. LOCATION (City, town, or county) (State) Balto., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | 25B. NAME OF REGISTRAR Witzke F.D. | | 25C. FUNERAL DIRECTOR ADDRESS 4101 Edmondson Ave. | |

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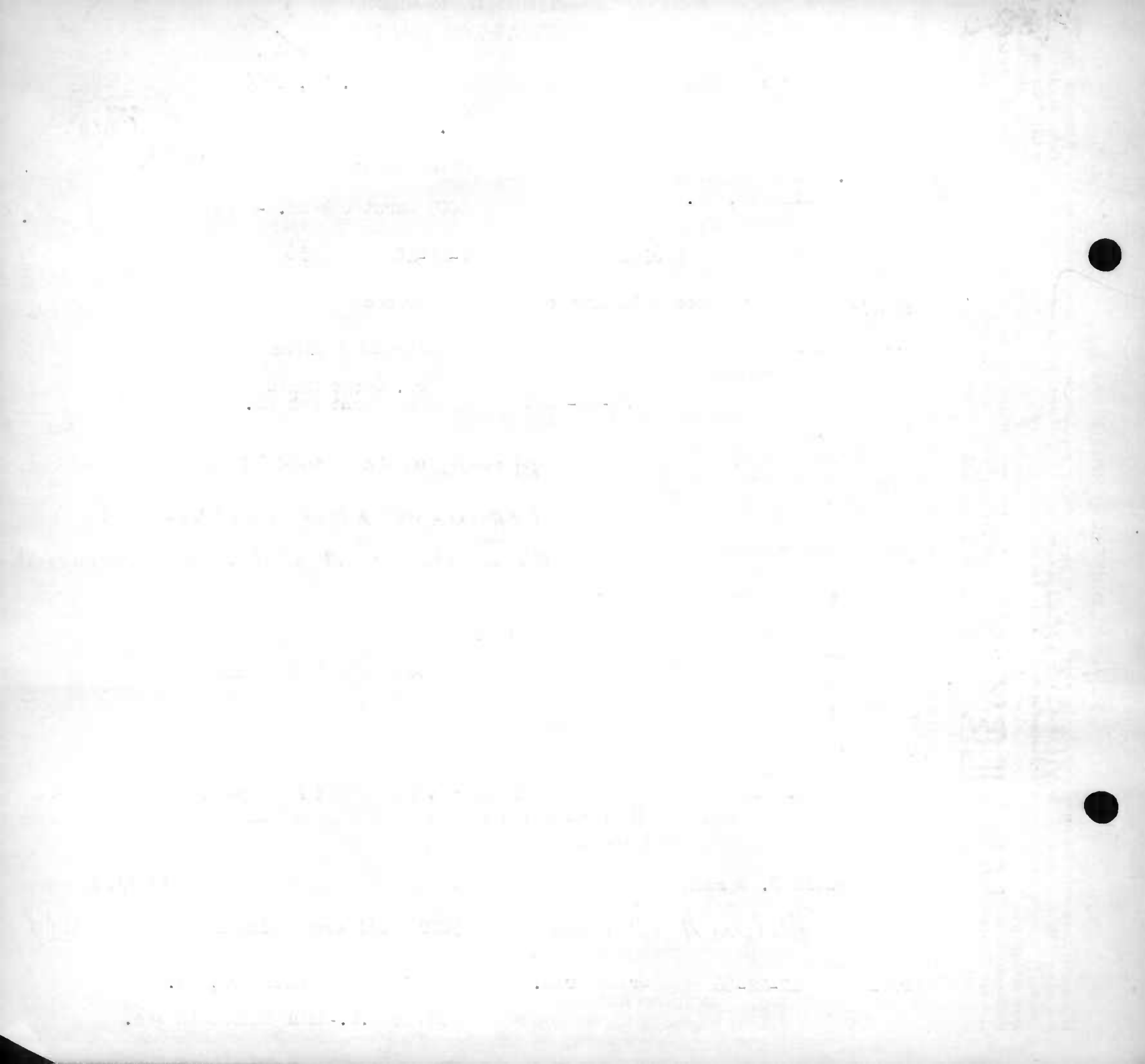
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

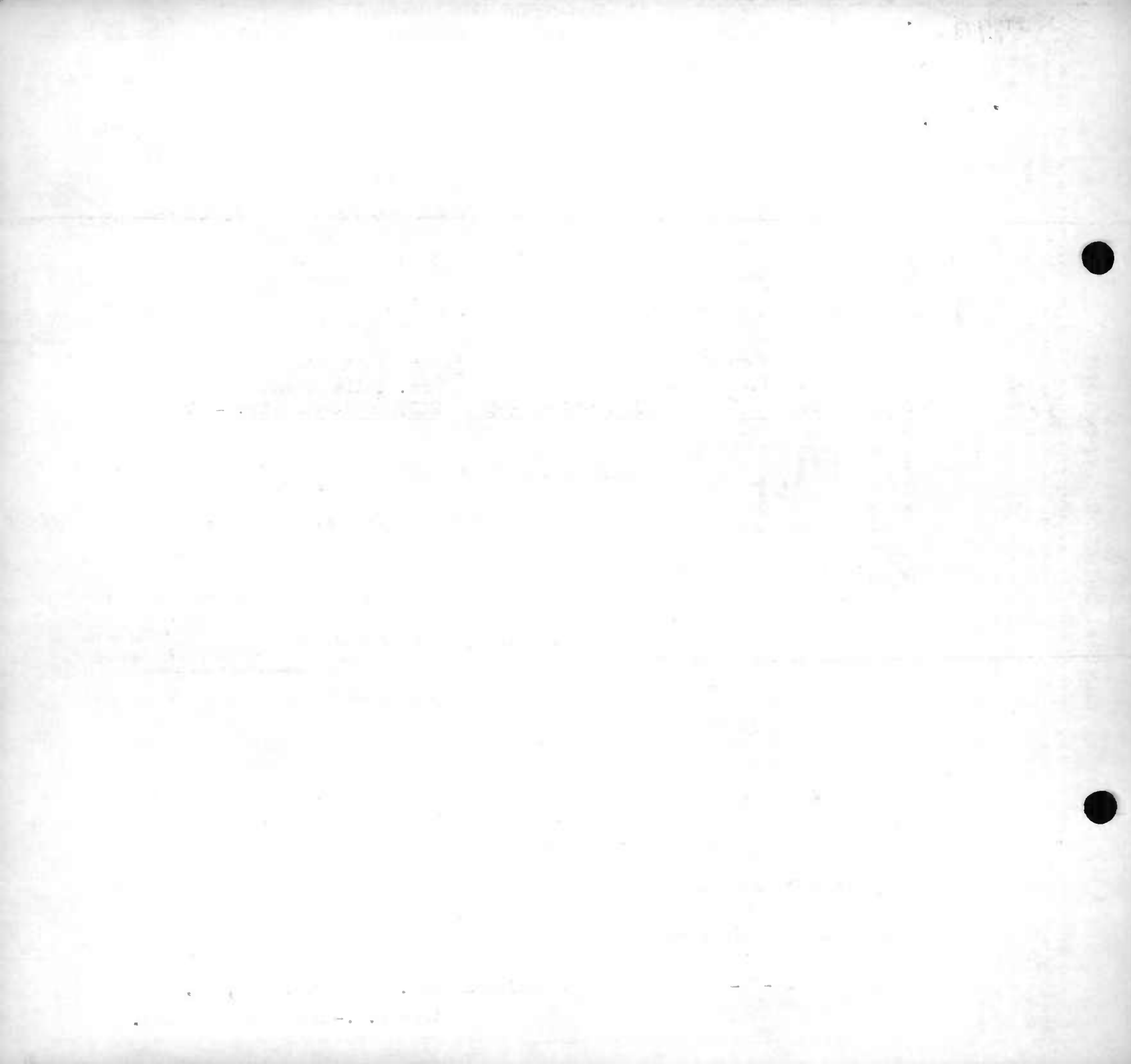
| BIRTH NO. 66 12983 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12983 | |
|--|----------------------|---|--|--|--|---|---------------------------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) George Menas | | | | 2. DATE AND HOUR OF DEATH Dec. 24, 1966 | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 40 St. Agnes Hospital Baltimore, Md. | | | | A. STATE Md. B. COUNTY Balt. Co. | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Catonsville | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 6009 Burnt Oak Rd. - #28 | | | |
| 5. SEX M | 6. RACE Wh | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 6-19-10 | 9. AGE (In years lost birthday) 56 | 10. Under 1 Yr. Months Days | 11. Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic | | | 10B. KIND OF BUSINESS OR INDUSTRY George's Garage | | 11. BIRTHPLACE (State or foreign country) Greece | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME John Menas | | | 14. MOTHER'S MAIDEN NAME Mercella Zanious | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. 217-32-8436 | | 17. INFORMANT Mrs. George Menas 6009 Burnt Oak Rd. | | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) MYOCARDIAL INFARCTION DUE TO (B) CORONARY ATHEROSCLEROSIS DUE TO and (C) Rheumatic Aortic Stenosis | | | INTERVAL BETWEEN ONSET AND DEATH 1 HOURS ? old (years) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While Work <input type="checkbox"/> At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from August 27 1963 to December 27 1966 , that (I) (we) last saw the deceased alive on December 13 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Melvin N. Borden | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 12/27/66 | |
| 23C. PHYSICIAN'S NAME (Type) Melvin N. Borden | | | | 23D. ADDRESS 5000 Baltimore National Pike Baltimore Md 21229 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-28-66 | | 24C. NAME of CEMETERY or CREMATORY Greek Orth. | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | 25B. NAME OF REGISTRAR Robert E. Schlegel | | 25C. FUNERAL DIRECTOR Witzke F.D. | | ADDRESS 4101 Edmondson Ave. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. | |
|--|------------------------|---|--|--|--|--|--|--|--|----------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | | 66 12984 | |
| BIRTH NO. 66 12984 | | M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | | 4 ³⁰ A | | M. | |
| 1. NAME OF DECEASED (Type or Print) LLOYD P. SHARP | | | | | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSP. OF BALT., INC. | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Balt Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 53-00 2029 WOODLAWN DRIVE | | | | | |
| 5. SEX M | 6. RACE CAU. | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) DIVORCED | | 8. DATE OF BIRTH 5/17/15 | 9. AGE (In years lost birthday) 51 | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN | | | | 10B. KIND OF BUSINESS OR INDUSTRY DAIRY (BREAD CO.) | | 13. FATHER'S NAME GROVER C. SHARP | | | 14. MOTHER'S MAIDEN NAME DELLA BOWEN | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, to or unknown) (If yes, give war or dates of service) Yes 1944-45 | | | | 16. SOCIAL SECURITY NO. 212-03-2376 | | 17. INFORMANT Mrs. Della Hughes | | | ADDRESS 2029 Woodlawn Drive - #7 | | |
| 18. 443 X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CEREBRO-VASCULAR ACCIDENT (HEMORRHAGE) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 weeks | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE | | | | | | 7+ years | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. GASTROINTESTINAL BLEEDING | | | | | | 10 days | | | | | |
| 19A. DATE OF OPERATION 0 NONE | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NONE | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/10 1966 to 12/23 1966 , that (I) (we) last saw the deceased alive on 12/23 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE J. Brett Lazar | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED 12/23/66 | | |
| 23C. PHYSICIAN'S NAME (Type) J. BRETT LAZAR | | | | | | 23D. ADDRESS M.D. SINAI HOSP. OF BALT., INC. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-27-66 | | 24C. NAME of CEMETERY or CREMATORY Baltimore National Cem. | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | | | 25B. NAME OF REGISTRAR E. J. ... | | 25C. FUNERAL DIRECTOR Witzke F.D. | | | ADDRESS 4101 Edmondson Ave. | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 12985 | | DEPARTMENT OF HEALTH | | Registered No. 66 12985 | |
|--|--------------------------------|--|--|--|---|
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <i>John S. Peters, Sr.</i> | | | 2. DATE AND HOUR OF DEATH <i>Dec 24, 1966</i> <i>7 P. M.</i> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Bon Secours Hospital</i> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md.</i> B. COUNTY _____ C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>622 Wicklow Rd #29</i> | | |
| 5. SEX <i>male</i> | 6. RACE <i>white</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>married</i> | 8. DATE OF BIRTH <i>7-18-00</i> | 9. AGE (In years last birthday) <i>66</i> | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Prop. Tavern</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Prop. Tavern</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Own Bus.</i> | | 11. BIRTHPLACE (State or foreign country) <i>Baltimore, md.</i> |
| 12. CITIZEN OF WHAT COUNTRY? | | | 13. FATHER'S NAME <i>George Peters</i> | | |
| 14. MOTHER'S MAIDEN NAME <i>Beatrice Peters</i> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | |
| 16. SOCIAL SECURITY NO. <i>212-32-8501</i> | | | 17. INFORMANT <i>Mrs. Beatrice Peters</i> <i>622 Wicklow Rd.</i> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>Perforated, bleeding Gastrojejunal ulcer</i> INTERVAL BETWEEN ONSET AND DEATH <i>3 mo</i> | | | 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Carcinoma pancreas metastasis to liver</i> <i>peritonitis</i> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Emphysema</i> <i>Chronic myocardial disease</i> | | |
| 19A. DATE OF OPERATION <i>12-23-66</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Bleeding ulcer</i> | | 20A. AUTOPSY? (Yes or No) <i>no</i> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21C. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21D. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21E. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>11-20-</i> <i>1966</i> to <i>12-24</i> <i>1966</i> , that (I) (we) lost saw the deceased alive on <i>12-24</i> <i>1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>S.G. Sullivan</i> | | | | 23B. DATE SIGNED <i>12-24-66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>S.G. Sullivan</i> | | | | 23D. ADDRESS M.D. <i>1129 St Paul St Baltimore 2 Md.</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12-29-66</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral Cem.</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 27 1966</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Feltner</i> | | 25C. FUNERAL DIRECTOR <i>Witzke F.D.</i> | |
| 25D. ADDRESS <i>4101 Edmondson Ave.</i> | | | | | |

14
J-520
66 12986

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12986

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Stanley W. Jones

2. DATE AND HOUR PRONOUNCED DEAD

12/24/66 4:00 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

46 Lutheran Hosp. - Balto., Md.
Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

810 Winans Way

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

9-5-01

9. AGE (in years
last birthday)

65

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Supervisor

10B. KIND OF BUSINESS OR INDUSTRY

Printing Co.

11. BIRTHPLACE (State or foreign country)

Wash., D. C.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Late - David Jones

14. MOTHER'S MAIDEN NAME

Late - Emma

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

216-03-8291

17. INFORMANT

Mrs. Mildred Jones
810 Winans Way

ADDRESS

18.

422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREWerner U. Spitz, M.D.
EXAMINER'S NAME (Type)CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/25/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12-28-66

23C. NAME of CEMETERY or CREMATORY

Woodlawn Cem.

23D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

DEC 27 1966

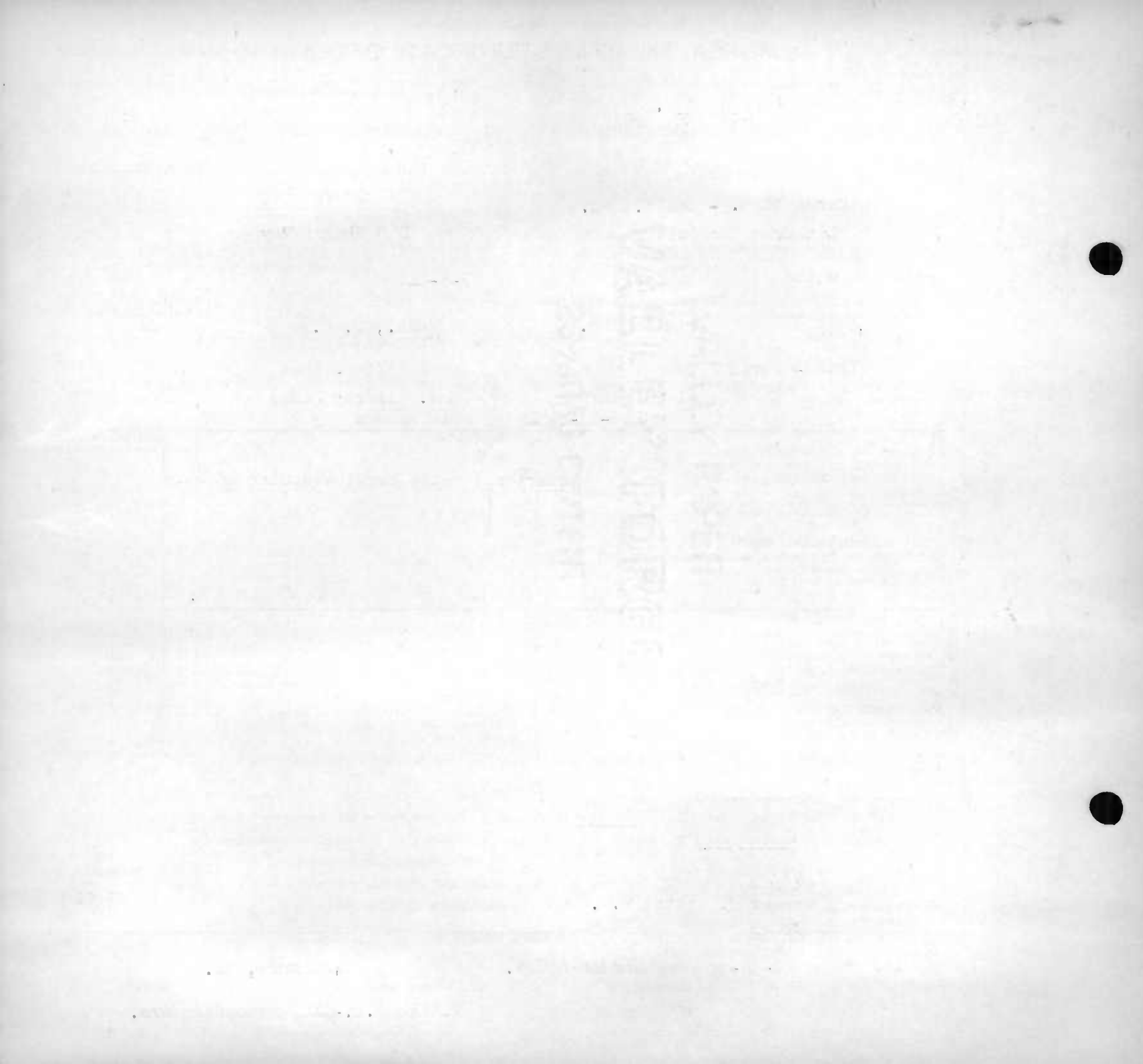
24B. NAME OF REGISTRAR

Robert E. Tolson

24C. FUNERAL DIRECTOR

Witzke F.D.-4101 Edmondson Ave.

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|----------------------|--|---|--|---|
| BIRTH NO. 66 12987 | | CERTIFICATE OF DEATH | | Registered No. 66 12987 | |
| M.E. CASE NO. MISS FLORENCE A. WAGNER | | | | | |
| 1. NAME OF DECEASED (Type or Print) Wagner, Florence | | | 2. DATE AND HOUR OF DEATH 9.45 pm. Dec 20. 1966 | | |
| 3. PLACE OF DEATH IN (BALTIMORE, MARYLAND) | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md B. COUNTY | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Union Memorial Hospital | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | |
| D. STREET ADDRESS (If rural, give location) 116 W. University Pkwy | | | E. CITY OR TOWN (If outside city limits, write RURAL and give township) 12-01 | | |
| 5. SEX F | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) M | 8. DATE OF BIRTH 06-10-79 | 9. AGE (In years last birthday) 85 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FUR BUYER, ONEILL & Co. | | | 11. BIRTHPLACE (State or foreign country) Md | | |
| 12. CITIZEN OF WHAT COUNTRY? American | | | 13. FATHER'S NAME Charles Wagner | | |
| 14. MOTHER'S MAIDEN NAME Mary Mc Grath | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS Mrs. EDMUND McCaffrey 116 W. Univ. Py. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular disease | | | INTERVAL BETWEEN ONSET AND DEATH One month | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) <u>(this hospital)</u> attended the deceased from Nov 30, 1966 to Dec 20, 1966 , that (I) <u>(we)</u> lost saw the deceased alive on 9.45 pm Dec 20, 1966 and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Sang Won Song | | | | 23B. DATE SIGNED Dec 20, 1966 | |
| 23C. PHYSICIAN'S NAME (Type) SANG WON SONG, M.D. | | | | 23D. ADDRESS THE UNION MEMORIAL HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12/23/66 | | 24C. NAME of CEMETERY or CREMATORY NEW CATHEDRAL | |
| 24D. LOCATION BALTIMORE, MD. | | 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | | |
| 25B. NAME OF REGISTRAR W. E. Jones | | 25C. FUNERAL DIRECTOR ADDRESS H.W. MEARS & SON 805 N. CALVERT ST. | | | |

XXXXXX
The Board of Directors
of the

The Maine Memorial Hospital
116 W. University Road
08-10-38
M White H

Charles Wagner
Mary Mc (Pratt)
M

Administrative (Executive) Office

Hand over hand
X
Dec 20 1966
Nov 30 1966
Dec 30 1966

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|-------------------------|--|---|--|--|---|--|---|--|
| 66 12988 | | | | | 66 12988 | | | | |
| BIRTH NO. | | | | | Registered No. | | | | |
| M.E. CASE NO. | | | | | CERTIFICATE OF DEATH | | | | |
| 1. NAME OF DECEASED (Type or Print) JOHN DOEBEREINER | | | | | 2. DATE AND HOUR OF DEATH 12-22-66 1:45 AM M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 MARYLAND GENERAL HOSPITAL | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Belts Co. D. STREET ADDRESS (If rural, give location) Box 157, Ave. B TODDS FARM | | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH Aug-12-1892 | 9. AGE (In years last birthday) 74 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired, Hostler | | | 10B. KIND OF BUSINESS OR INDUSTRY RAIL ROAD | | 11. BIRTHPLACE (State or foreign country) GERMANY | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. ? | |
| 13. FATHER'S NAME GEORGE Doebereiner | | | | | 14. MOTHER'S MAIDEN NAME Christina Moore | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. 705-10-9631 | | 17. INFORMANT WIFE - Ethel | | | ADDRESS As Above | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinoma of stomach | | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO probable pulmonary embolus | | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 12-16-66 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ca stomach | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-3 1966 to 12-22 1966 , that (I) (we) last saw the deceased alive on 12-21-66 1966 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE GARY LEE NUBEL M.D. | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED 12-22-66 | |
| 23C. PHYSICIAN'S NAME (Type) GARY LEE NUBEL | | | | | 23D. ADDRESS 2703-A ANDOVER ST BALTO. MD | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 24B. DATE 12-24-1966 | | 24C. NAME OF CEMETERY or CREMATORY Oak Lawn | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland 21224 | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | | 25B. NAME OF REGISTRAR John J. Duda | | | 25C. FUNERAL DIRECTOR ADDRESS JOHN J. DUDA, Dundalk, Maryland 21222 | | | |

...

General of the
United States Army

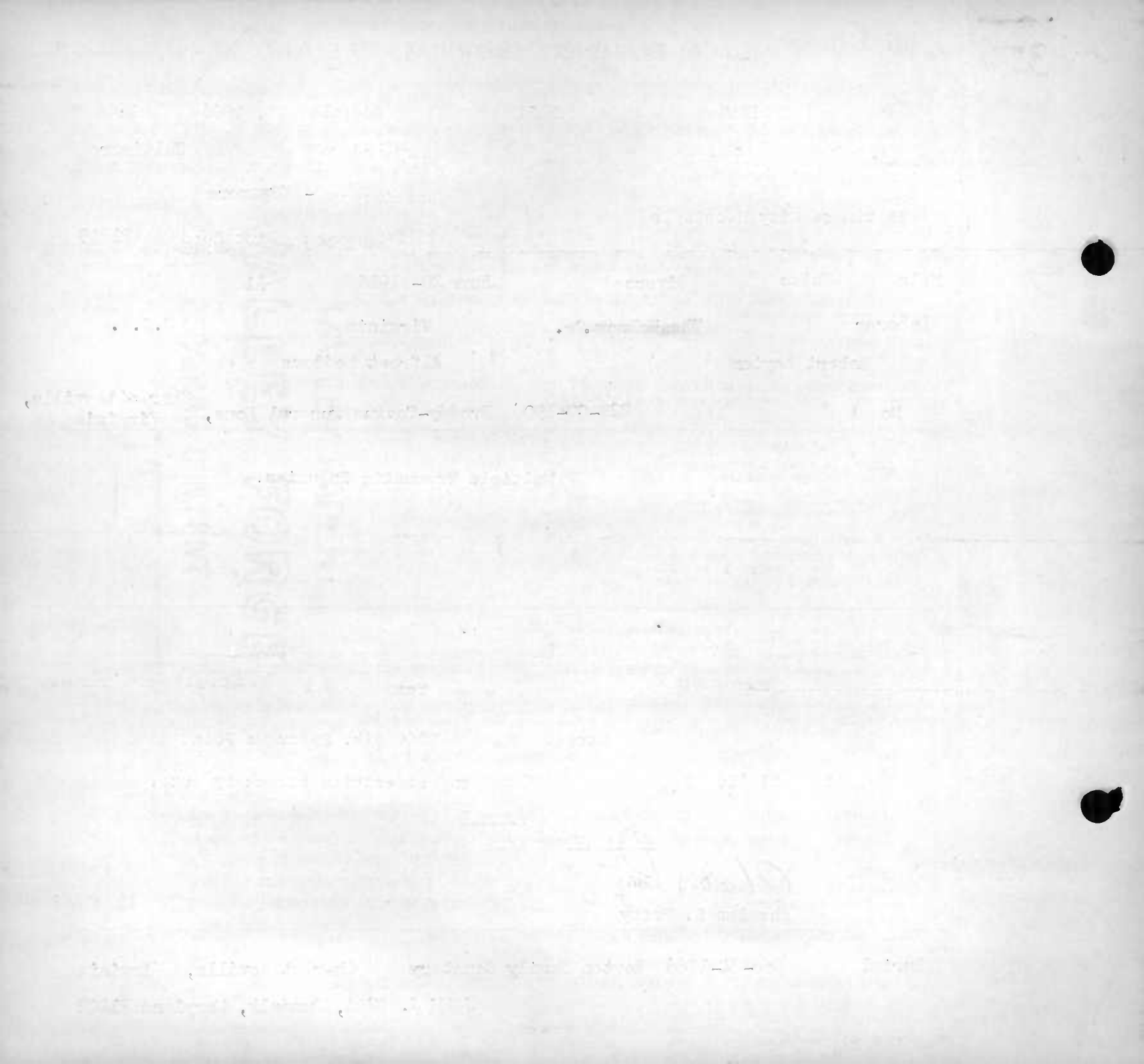
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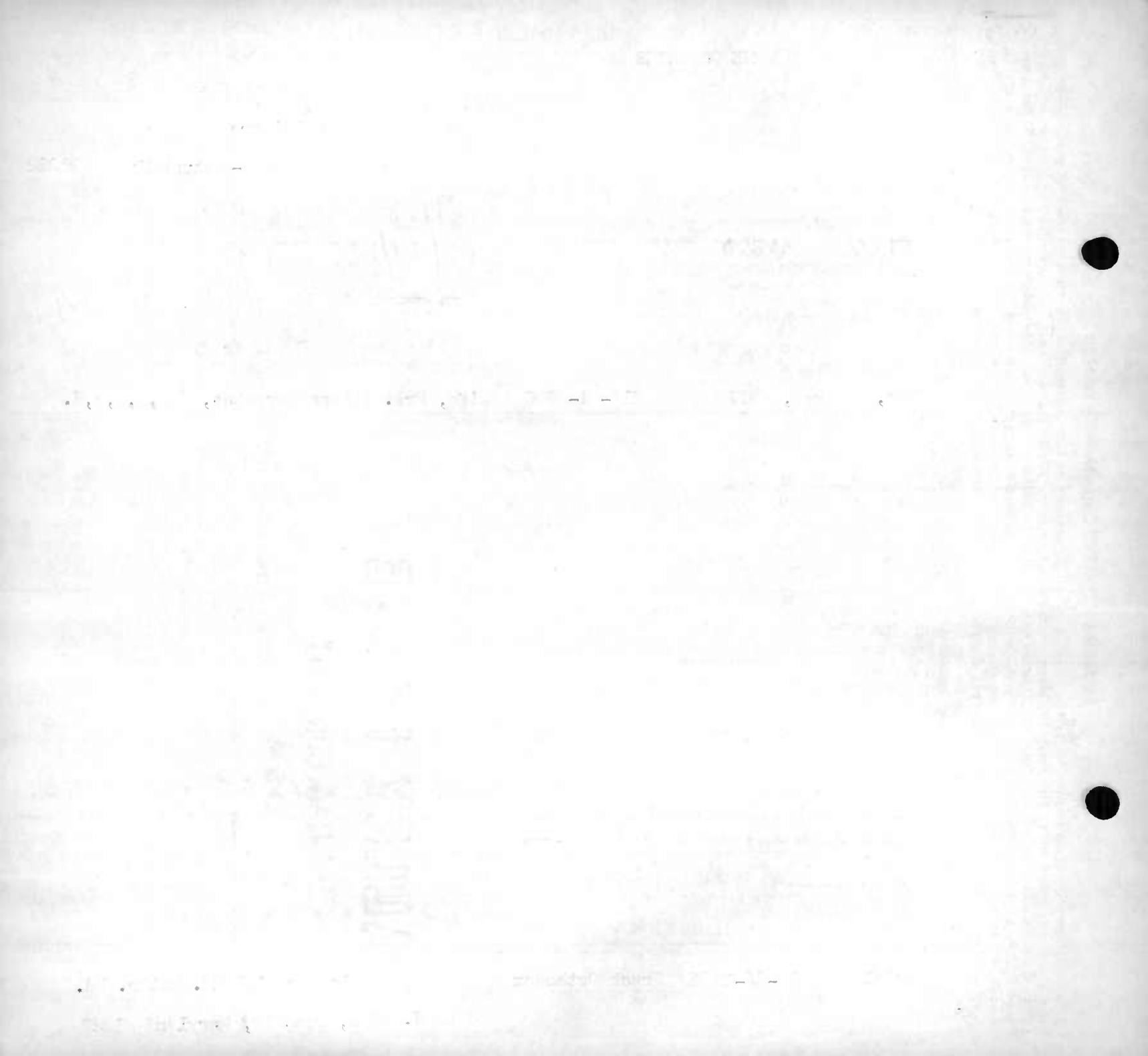
| BALTIMORE CITY HEALTH DEPARTMENT | | | |
|---|--|---|--|
| BIRTH NO. 66 12989 | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12989 | |
| M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR PRONOUNCED DEAD | |
| ERNEST KEYTON | | December 21, 1966 7:44 P M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE B. COUNTY | |
| 31 Baltimore City Hospitals | | Maryland Baltimore | |
| | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | |
| | | Baltimore - Edgemere 53-00 | |
| | | D. STREET ADDRESS (If rural, give location) | |
| | | 2515 Sparrows Point Road 21219 | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH |
| Male | White | Divorced | June 20- 1915 |
| 9. AGE (In years last birthday) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 11. BIRTHPLACE (State or foreign country) |
| 51 | Laborer | | Virginia |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | |
| U.S.A. | | Robert Keyton | |
| 14. MOTHER'S MAIDEN NAME | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | |
| Alfreath Beddows | | No | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 229-07-1908 | | Charlottesville, Virginia | |
| 18. CAUSE OF DEATH | | 19. PRETTY-TEAGUE FUNERAL HOME, VIRGINIA | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | |
| ANTECEDENT CAUSES | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | |
| II | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 0 | | Yes | Yes |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | Street | 2800 Blk. Sparrows Point Road 53-00 | |
| 21D. TIME OF INJURY (APPROX.) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | Pedestrian struck by auto. | |
| 12 21 '66 P | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| Charles S. Petty | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | |
| Burial | | Dec-24-1966 | |
| 23C. NAME of CEMETERY or CREMATORY | | 23D. LOCATION (City, town, or county) (State) | |
| Keyton Family Cemetery | | Charlottesville, Virginia | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | |
| DEC 27 1966 | | John J. Duda | |
| 24C. FUNERAL DIRECTOR ADDRESS | | 24D. DATE | |
| JOHN J. DUDA, Dundalk, Maryland 21222 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 12990 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12990 | |
|--|--------------------------------|---|--|---|---|
| CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>George Govostes</u> | | | 2. DATE AND HOUR OF DEATH <u>12/22/66 18:45 A.M.</u> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Maryland General Hospital</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Baltimore Co.</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore - Dundalk 21222</u> D. STREET ADDRESS (If rural, give location) <u>8118 Gray Haven Rd 53-00</u> | | |
| 5. SEX <u>Male</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u> | 8. DATE OF BIRTH <u>12/27/17</u> | 9. AGE (In years last birthday) <u>48</u> | 10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Arc-Rod. Co.</u> | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>Gus Govostes</u> | | | 14. MOTHER'S MAIDEN NAME <u>Mary Karas</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes, Army, WWII</u> | | 16. SOCIAL SECURITY NO. <u>218-01-8780</u> | 17. INFORMANT <u>Wife, Mrs. Athena Govostes, # 4,a,b,c,d.</u> | | |
| 18. <u>422.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | CAUSE OF DEATH (A) <u>Congestive Heart Failure</u> DUE TO (B) <u>unknown - arteriosclerotic</u> DUE TO (C) <u>C-V Disease suspected</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>Years</u> |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <u>MD</u> (this hospital) attended the deceased from <u>12/9</u> 19 <u>66</u> to <u>12/22</u> 19 <u>66</u> , that <u>MD</u> (we) last saw the deceased alive on <u>12/22</u> 19 <u>66</u> and that <u>MD</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>MD</u> (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Bernard du Bay</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED <u>12/22/66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Bernard du Bay</u> | | 23D. ADDRESS <u>Maryland General Hospital</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | 24B. DATE <u>12-26-1966</u> | 24C. NAME of CEMETERY or CREMATORY <u>Greek Orthodox</u> | | 24D. LOCATION (City, town, or county) (State) <u>Windsor Mill Rd. Balto. Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 27 1966</u> | | 25B. NAME OF REGISTRAR <u>John J. Duda</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>JOHN J. DUDA, Dundalk, Maryland 21222</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|--|-------------------------------------|--|--|
| BIRTH NO. 66 12991 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12991 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED MARY M. WIERS <i>Wiers, Mary Margaret</i> | | 2. DATE AND HOUR OF DEATH 1:30 AM Dec 21, 1966 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Union Memorial Hospital | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2936 Wyman Parkway | | | |
| 5. SEX F | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never | 8. DATE OF BIRTH 08-07-86 | 9. AGE (In years last birthday) 80 | 10. If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SCHOOL PRINCIPAL-PUBLIC | | 10B. KIND OF BUSINESS OR INDUSTRY SCHOOL SYSTEM | | 11. BIRTHPLACE (State or foreign country) MD | |
| 13. FATHER'S NAME William H. Wiers | | 14. MOTHER'S MAIDEN NAME Ellen Thompson | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT MISS COLETTE WIERS 2936 WYMAN PKY | |
| 18. 170 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Breast cancer, metastasis to pleura, et. adenal. bone. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. atelectasis of Rt. lung due to pleural effusion. | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH 4 1/2 hrs | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) <u>(this hospital)</u> attended the deceased from 1:30pm Dec 17, 1966 to 1:30 AM Dec 21, 1966 , that (I) <u>(we)</u> last saw the deceased alive on 1:30 AM Dec 21, 1966 and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Sang Won Song | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED Dec 21, 1966 | |
| 23C. PHYSICIAN'S NAME (Type) SANG WON SONG, M.D. | | 23D. ADDRESS THE UNION MEMORIAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12.24/66 | | 24C. NAME OF CEMETERY or CREMATORY NEW CATHEDRAL | |
| 24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND | | 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR H.W. MEARS & SON 805 N. CALVERT ST. | | | |

Wicks Mary Margaret

1-3-44 Death

The Union Memorial Hospital

2438 Wyman Parkway
Baltimore

08-03-80 20

White Mary

American

NYC

Ellen Thompson

William H. Wicks

Officer
Citation of Mr. and Mrs. Wicks
at home. One
- Great center, attention to glass

Mr. K. Kim

1:30pm Dec 17 66
1:30pm Dec 17 66

Dec 21, 1966

King Wm King

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 86 12992 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 86 12992 | |
|---|----------------------------|--|---|---|--|
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <i>Rosalie - Rosalia MODO</i> | | 2. DATE AND HOUR OF DEATH <i>12/21/66 8:20 P.M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>MERCY HOSP</i> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>27-05</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore #34</i> D. STREET ADDRESS (If rural, give location) <i>3530 Woodring Ave</i> | | | |
| 5. SEX <i>Female</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widow</i> | 8. DATE OF BIRTH <i>7/15/89</i> | 9. AGE (In years last birthday) <i>77</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>house wife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Italy</i> | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> |
| 13. FATHER'S NAME <i>Salvatore Giordano</i> | | 14. MOTHER'S MAIDEN NAME <i>Rosalia CRACIA</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>216-16-4694</i> | | 17. INFORMANT <i>Angela Davis</i> ADDRESS <i>3530 Woodring Ave</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH <i>CA of Cervix w metastases</i> (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH <i>> 1 yr.</i> | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>II</i> | | <i>ABNORMAL WCTF + Cerebrin + Diabetic</i> | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from <i>12/2</i> 19 <i>66</i> to <i>12/21</i> 19 <i>66</i> that (we) lost saw the deceased alive on <i>12/21</i> 19 <i>66</i> and that in (our) opinion death occurred on the date and hour and from the causes stated above <i>(We) (did) (not) view the body after death.</i> | | | | | |
| 23A. SIGNATURE <i>Dr. M. France</i> | | 23B. DATE SIGNED <i>12/21/66</i> | | 23C. PHYSICIAN'S NAME (Type) <i>JOSEPH M. FRANCE</i> | |
| 23D. ADDRESS <i>MERCY HOSP</i> | | 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | | |
| 24B. DATE <i>12/26/66</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemers</i> | | 24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 27 1966</i> | | 25B. NAME OF REGISTRAR <i>Frank Dulla</i> | | 25C. FUNERAL DIRECTOR <i>322 S High St</i> | |

Handwritten text at the top of the page, possibly a header or title, including the word "REPORT".

First main paragraph of handwritten text, starting with "The purpose of this report is to..."

Second main paragraph of handwritten text, continuing the narrative or analysis.

Third main paragraph of handwritten text, providing further details or conclusions.

Final handwritten text at the bottom of the page, possibly a signature or footer.

FUNERAL DIRECTOR: IMPORTANT

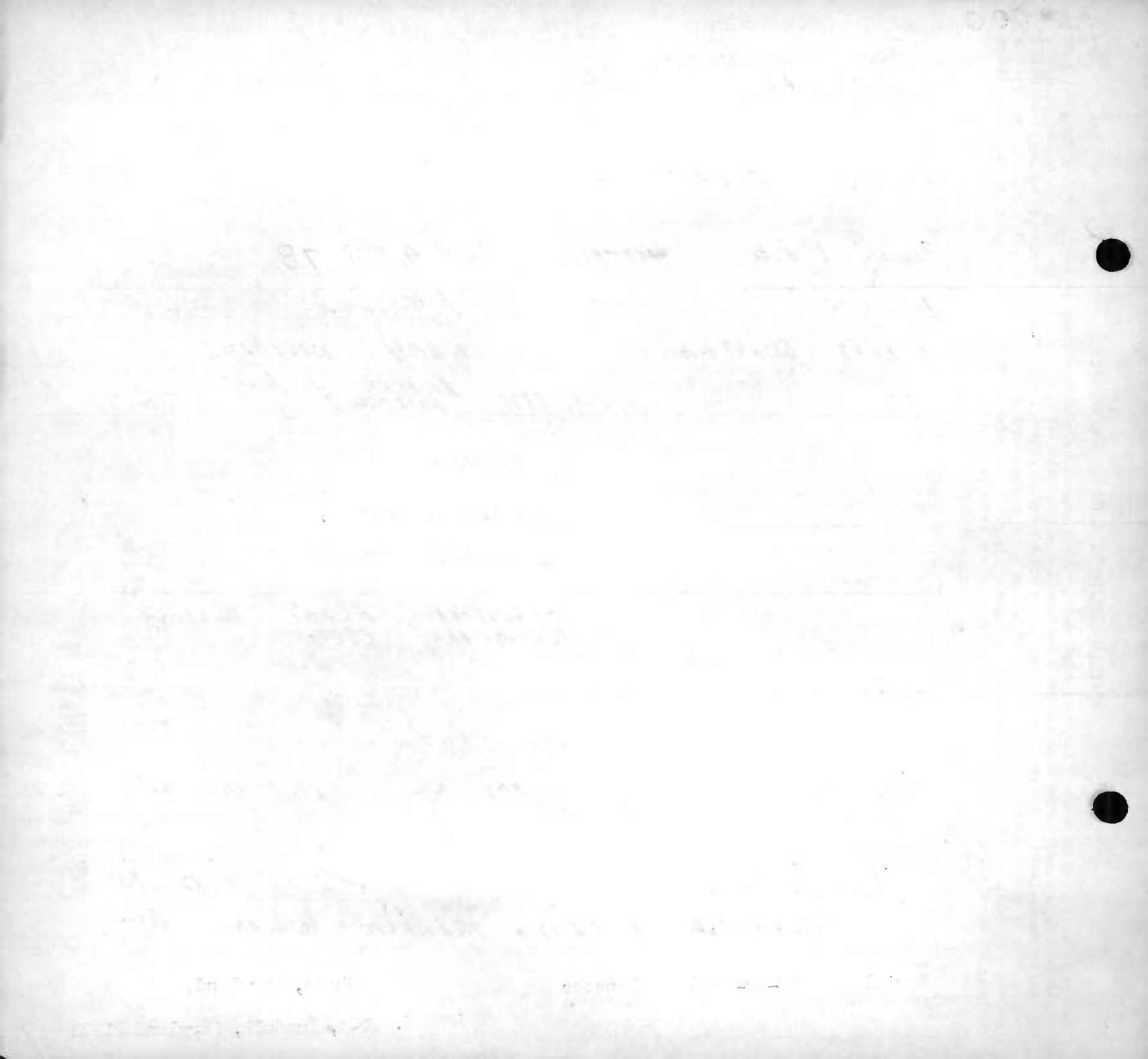
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|------------------|---|------------------------------------|
| <div style="display: flex; justify-content: space-between;"> BIRTH NO. 66 12993 BALTIMORE CITY HEALTH DEPARTMENT Registered No. 66 12993 </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2> | | | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type of final) ROBERTSON, DIEBIE | | 2. DATE AND HOUR OF DEATH 12/23/66 2:45 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITY HOSP | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY BALTO C. CITY OR TOWN (If outside city limits, give RURAL and give township) Balto D. STREET ADDRESS (If rural, give location) 2115 W. Lexington St | |
| 5. SEX F | 6. RACE N | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH 11/4/66 |
| 9. AGE (In years last birthday) 6 | | If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME NILES MADISON | | 14. MOTHER'S MAIDEN NAME LOLA ROBERTSON | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT | | ADDRESS | |
| 18. 193.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) RECURRENT GLIOMA (4) hemispheric | | INTERVAL BETWEEN ONSET AND DEATH 4 yrs | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/22/66 to 10/23 19 66 , that (I) (we) lost saw the deceased alive on 12/23 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Arnoldo Sepulveda | | 23B. DATE SIGNED 12/23/66 | |
| 23C. PHYSICIAN'S NAME (Type) ARNOLDO SEPULVEDA | | 23D. ADDRESS UNIVERSITY HOSP | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | |
| 24C. NAME OF CEMETERY or CREMATORY Burial 6 12/29/66 Mt Calvary | | 24D. LOCATION (City, town, or County) (State) Brooklyn Balto, MD | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | |
| 25C. FUNERAL DIRECTOR | | 25D. ADDRESS | |
| DEC 27 1966 | | Sharon Wilson 5137, Calvary St | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 12994 | |
|--|----------------------|--|---------------------------------------|---|---|
| BIRTH NO. 66 12994 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) ALBERTA M. HARE | | 2. DATE AND HOUR OF DEATH DEC. 24, 1966 8:00 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) FRANKLIN SQUARE Hosp. 36 | | A. STATE MARYLAND B. COUNTY BALTIMORE Co. | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-00 | | | |
| | | D. STREET ADDRESS (If rural, give location) HOPKINS ROAD, CHASE | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH April 4, 1888 | 9. AGE (In years last birthday) 78 | 10. If Under 1 Yr. Months: Days: II Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 13. FATHER'S NAME ROBERT SWEETMAN | | 14. MOTHER'S MAIDEN NAME MARY WILLIAMS | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 24-14-8930 | | 17. INFORMANT ANDREW S. HARE HUSBAND ADDRESS MARILYN CHASE, CHASE | |
| 18. 260X I | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) UREMIA | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | DUE TO | | | |
| ANTECEDENT CAUSES | | (B) NEPHROSCLEROSIS | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | DUE TO | | | |
| | | (C) DIABETES MELLITUS | | | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. COAGULATIVE DEFECT HEART FAILURE PULMONARY EDEMA | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Nov. 30, 1966 to Dec. 24, 1966 , that (I) (we) last saw the deceased alive on Dec. 24, 1966 and that in (my) (our) opinion, death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Michael | | | | 23B. DATE SIGNED 12-25-66 | |
| 23C. PHYSICIAN'S NAME (Type) HILAGROSA R. CALIZ M.D. | | | | 23D. ADDRESS FRANKLIN SQUARE Hosp. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-28-1966 | | 24C. NAME OF CEMETERY or CREMATORY Ebenezer | |
| | | | | 24D. LOCATION (City, town, or county) (State) Chase, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | 25B. NAME OF REGISTRAR John J. Duda | | 25C. FUNERAL DIRECTOR ADDRESS JOHN J. DUDA, Dundalk, Maryland 21222 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

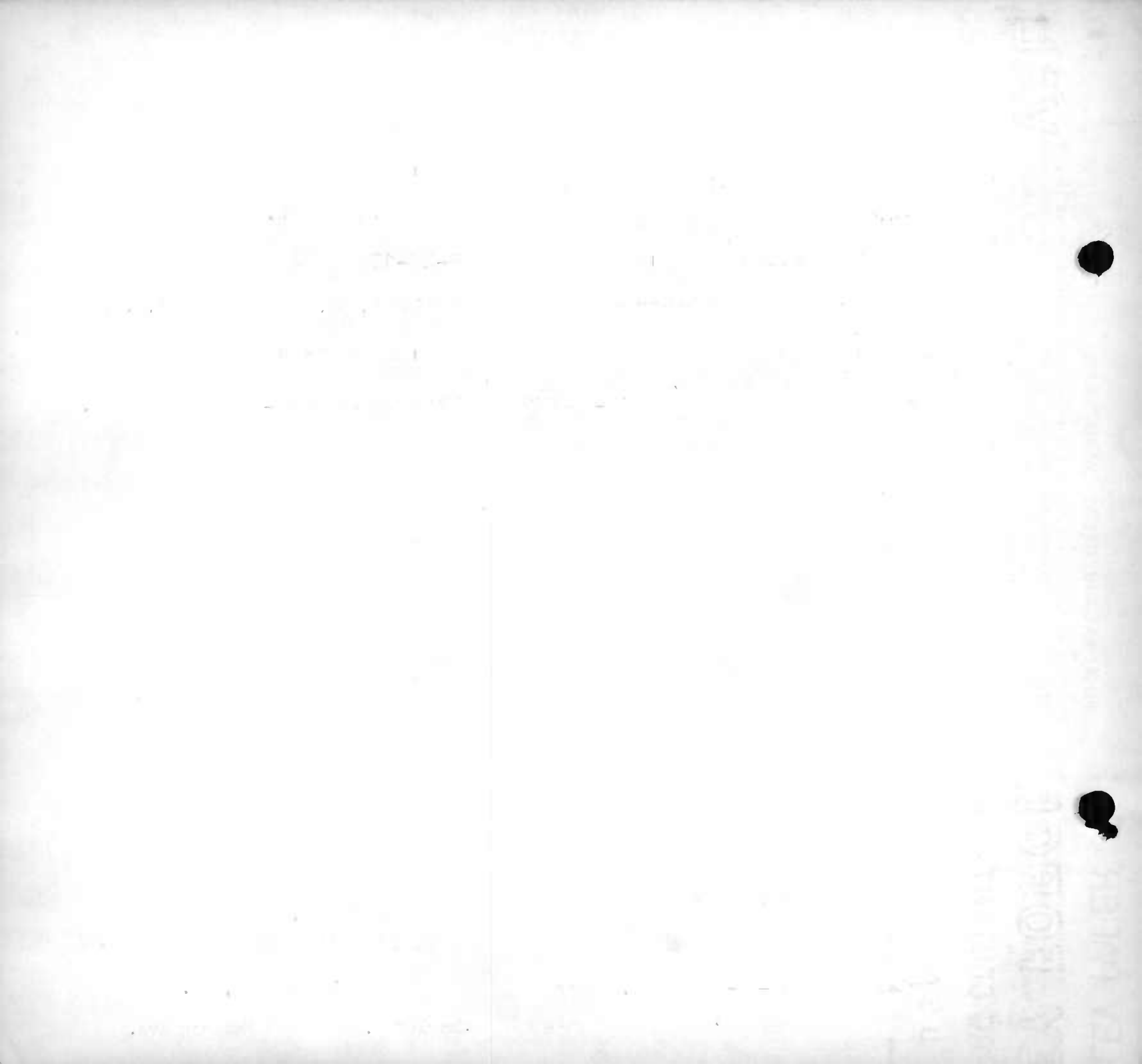
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 66 12995 | |
|---|-------------------------|--|--|--|--|
| CERTIFICATE OF DEATH | | | | Registered No. | |
| BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <u>VERNON Tykes</u> | | | 2. DATE AND HOUR OF DEATH <u>12-26-66</u> <u>12:40 A.M.</u> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) <u>46 LUTHERAN HOSPITAL OF MARYLAND</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY _____ C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>15-38</u> | | |
| 5. SEX <u>MALE</u> | 6. RACE <u>NEGRO</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widower</u> | 8. DATE OF BIRTH <u>10-7-1893</u> | 9. AGE (In years last birthday) <u>73</u> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel</u> | 11. BIRTHPLACE (State or foreign country) <u>Isle of Wight, Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME <u>George Tykes</u> | | | 14. MOTHER'S MAIDEN NAME <u>Ida Everett</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>-</u> | 17. INFORMANT <u>CHART</u> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>286.3 I</u> <u>MALNUTRITION</u> (A) DUE TO <u>UNKNOWN CAUSE</u> (B) DUE TO <u>UNKNOWN.</u> (C) _____ | | | INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN.</u> | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>DEC 25</u> 19 <u>66</u> to <u>DEC 25</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>DEC 26</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Young Kil Kim</u> | | | | 23B. DATE SIGNED <u>12/26/66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>YOUNG KIL KIM</u> | | | | 23D. ADDRESS <u>M.D. LUTHERAN HOSPITAL OF MARYLAND</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12-31-66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Mt. Calvary</u> | |
| 24D. LOCATION <u>Baltimore, Md.</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 27 1966</u> | | | |
| 25B. NAME OF REGISTRAR <u>Charles R. Law</u> | | 25C. FUNERAL DIRECTOR <u>Charles R. Law</u> | | | |
| 25D. ADDRESS <u>802 Madison Ave.</u> | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 12996 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12996 | |
|--|-------------------------|---|-------------------------------------|---|---|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <u>GEORGE T. BROWN</u> | | | | 2. DATE AND HOUR OF DEATH <u>12/23/66</u> <u>6:40 PM.</u> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <u>THE JOHNS HOPKINS HOSPITAL</u> <u>33</u> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>906 WHATCOAT ST.</u> | | | |
| 5. SEX <u>MALE</u> | 6. RACE <u>NEGRO</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>SINGLE</u> | 8. DATE OF BIRTH <u>03-22-13</u> | 9. AGE (In years last birthday) <u>53</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Construction</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>JOSEPH BROWN</u> | | | | 14. MOTHER'S MAIDEN NAME <u>LIZA GOODMAN</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>218-14-1276</u> | | 17. INFORMANT ADDRESS <u>Katherine Jackson - 906 Whatcoat St.</u> | | | |
| 18. <u>15381</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH (A) <u>Cardiac & respiratory arrest</u> DUE TO (B) <u>Myocardial failure</u> DUE TO (C) <u>Circumstances of colon - neoplastic</u> | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>YES</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12/14</u> 19 <u>66</u> to <u>12/23</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12/23</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Kenneth L. Brigham</u> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>12/23/66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>KENNETH L. BRIGHAM</u> | | | | 23D. ADDRESS M.D. <u>The Johns Hopkins Hosp</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12-29-66</u> | | 24C. NAME of CEMETERY or CREMATORY <u>St. Lukes</u> | | 24D. LOCATION (City, town, or county) <u>Reisterstown, Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR <u>Charles R. Law</u> | | ADDRESS <u>802 Madison Ave.</u> | |



B-240

66 12997

BALTIMORE CITY HEALTH DEPARTMENT

66 12997

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HERBERT BEASLEY (BEASLEY)

2. DATE AND HOUR PRONOUNCED DEAD

December 22, 1966

6:25 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTYFULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1938 Mc Culloh Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)
Widowed

8. DATE OF BIRTH

Feb. 2, 1896

9. AGE (In years
last birthday)

70

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Alabama

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Unknown

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Edna B. Newton - 255 Robert St.

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Recent hemorrhage into old
organizing subdural membranes

(A) DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Unknown

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Unknown

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

Unknown

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

Unknown, presumably fell

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

December 23, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12-24-66

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

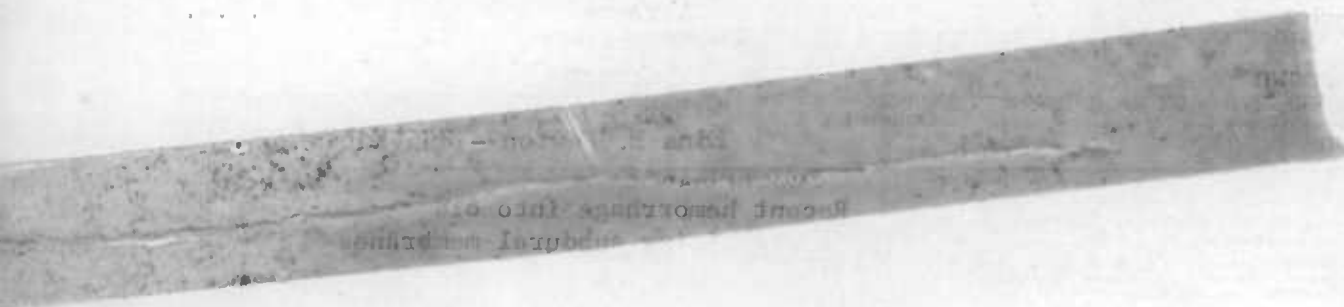
24C. FUNERAL DIRECTOR

ADDRESS

DEC 27 1966

Charles R. Law

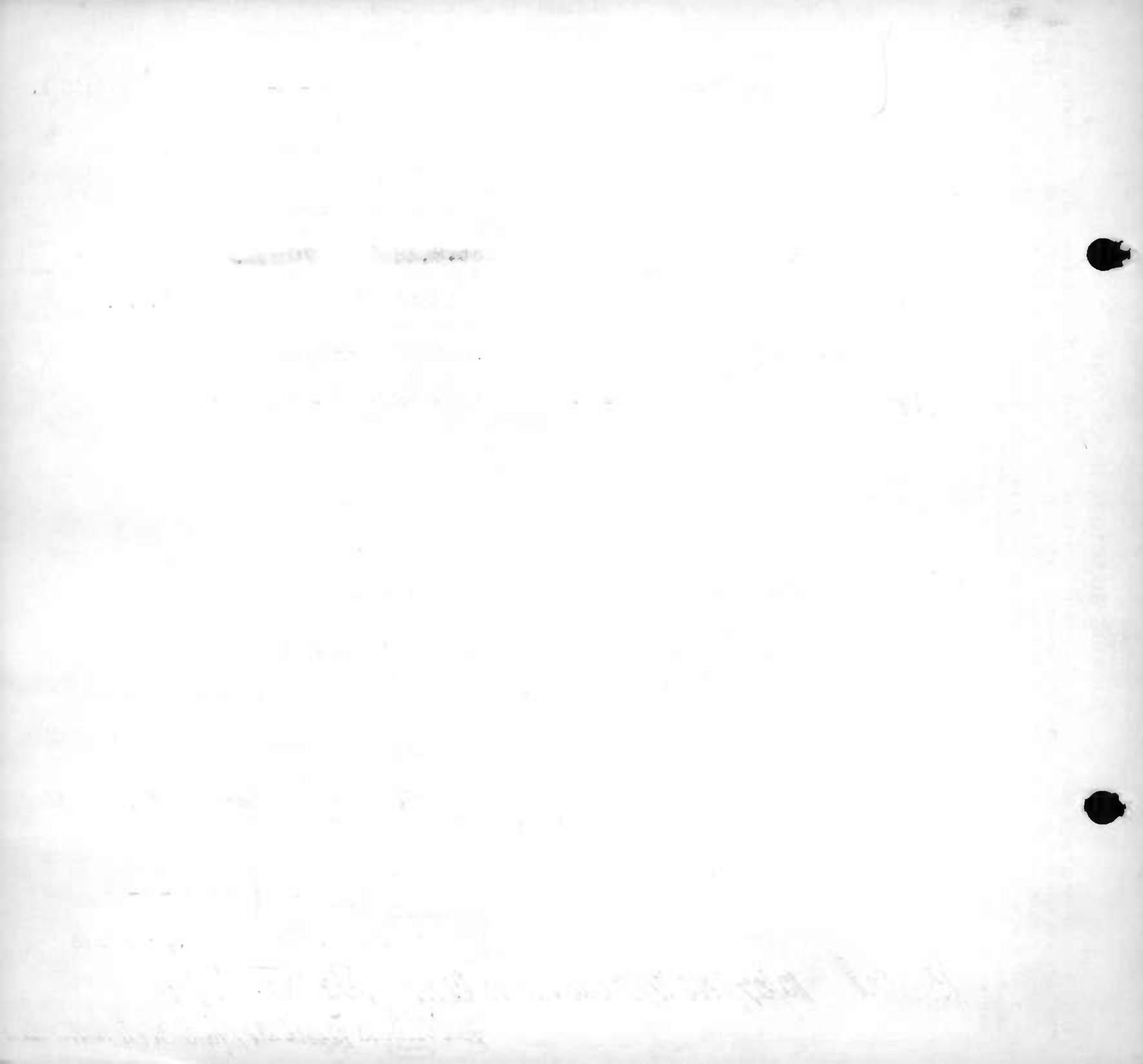
802 Madison Ave.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 12998 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 12998 | |
|--|-------------------------|---|---|--|--|--|---|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Lucy Jackson | | | | 2. DATE AND HOUR OF DEATH 12-21-66 8:50 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF INSTITUTE (If not in hospital or institution, give sheet address or location) Provident Hospital 39 | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, D. STREET ADDRESS (If rural, give location) 1518 Shields Place 14-02 | | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Separated | 8. DATE OF BIRTH Oct. 8, 1896 | 9. AGE (In years last birthday) 70 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Joshua Marshall | | | 14. MOTHER'S MAIDEN NAME Lucinda Matthews | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 217-09-7483 | | 17. INFORMANT Annie Robinson - daughter | | ADDRESS SAME |
| 18. 5-78X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) DUE TO Gangrene of small intestine due to compression (B) DUE TO of the most recent type (C) created with ingested | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from November 15, 1966 to December 21, 1966 , that (I) (we) last saw the deceased alive on December 21, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Parks | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-22-66 | |
| 23C. PHYSICIAN'S NAME (Type) Parks | | | | 23D. ADDRESS M.D. 1514 Division Street Balto., Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/27/66 | | 24C. NAME OF CEMETERY OR CREMATORY W. H. H. Burn Camp Balto. Md. | | 24D. LOCATION (City, town, or county) (State) Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | 25B. NAME OF REGISTRAR D. E. Jones | | 25C. FUNERAL DIRECTOR Williams Funeral Home | | ADDRESS 3197 Schenck St. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 12999</u> | |
|--|---------------------------|---|-----------------------------------|--|---|
| BIRTH NO. <u>66 12999</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Mary Sutton</u> | | 2. DATE AND HOUR OF DEATH <u>12-23-66</u> <u>7:30 A.M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>19-04</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> <u>21223</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>34 Bon Secours Hospital</u> | | D. STREET ADDRESS (If rural, give location) <u>540 Addison Street</u> | | | |
| 5. SEX <u>Female</u> | 6. RACE <u>Colored</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>4-9-05</u> | 9. AGE (In years last birthday) <u>61</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>United States</u> | | 13. FATHER'S NAME <u>Not known James Jones</u> | | 14. MOTHER'S MAIDEN NAME <u>Lucy Gibbs</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Rhodie Sutton</u> ADDRESS <u>540 Addison St.</u> | |
| 18. <u>442X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (B) <u>HYPERTENSIVE CARDIO-RENAL DISEASE WITH UREMIA</u> (A) DUE TO (C) <u>CEREBRAL HEMORRHAGE</u> (D) DUE TO (E) <u>UREMIC PERICARDITIS</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u> <u>7 weeks</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | <u>Pulmonary infarct, RLL</u> | | <u>2 weeks</u> | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>YES</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u> | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>November 6, 1966</u> to <u>Dec 23, 1966</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>Dec 23, 1966</u> and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <u>Dae Hun Kim</u> M.D. | | 23B. DATE SIGNED <u>Dec 23, 1966</u> | | 23C. PHYSICIAN'S NAME (Type) <u>DAE HUN KIM</u> M.D. | |
| 23D. ADDRESS <u>Bon Secours Hospital, Baltimore</u> | | 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12/27/1966</u> | |
| 24C. NAME OF CEMETERY or CREMATORY <u>St. Mary's Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Cades Hill Md</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 27 1966</u> | |
| 25B. NAME OF REGISTRAR <u>R. J. E. [unclear]</u> | | 25C. FUNERAL DIRECTOR <u>Williams Funeral Home</u> | | 25D. ADDRESS <u>519 N. Schroeder St.</u> | |

Female Colored married
Ben Secours Hospital

4-0-00

next - Kennedy - Mrs. Lucy Gibbs

Identification and history

HYPERTENSIVE C-RTS. CASE
DISEASE WITH C-RTS
GENERAL NERVOUSNESS

Chronic Nephritis

Proteinuria - 100 mg. / 24 hr.

Yes

Dec 23 1900

against the body

Medical Record from 1900

CERTIFICATE OF DEATH

Registered No. 66 13000

| | | | |
|---|-------------------------|--|--|
| BIRTH NO. 66-13000 | | BALTIMORE CITY HEALTH DEPARTMENT | |
| M.E. CASE NO. | | Registered No. 66 13000 | |
| 1. NAME OF DECEASED (Type or Print) Petro Pini | | 2. DATE AND HOUR OF DEATH 12/25/66 8 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) DALTON 53-00 D. STREET ADDRESS (If rural, give location) 3004 HISS AVENUE - #21234 | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 12/8/97 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hotel | | 10B. KIND OF BUSINESS OR INDUSTRY COOK | 9. AGE (In years last birthday) 69 |
| 11. BIRTHPLACE (State or foreign country) Italy | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME PAUL Pini | | 14. MOTHER'S MAIDEN NAME Adelaide | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 215-01-2906 | |
| 17. INFORMANT #21224 | | ADDRESS RECORDS-BCH-4940 EASTERN AVENUE | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Generalized arteriosclerosis Cerebrovascular accident | | INTERVAL BETWEEN ONSET AND DEATH 5 years - | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO pneumonia | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Severe pyelonephritis - | | (C) DUE TO | |
| 19A. DATE OF OPERATION 10/6/66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Gangrene of leg | |
| 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/4/66 to 12/25/66 and that (I) (we) last saw the deceased alive on 12/25/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE V. Hernandez | | 23B. DATE SIGNED 12/25/66 | |
| 23C. PHYSICIAN'S NAME (Type) DR. V. HERNANDEZ | | 23D. ADDRESS BCH-4940 EASTERN AVENUE-BALTIMORE, MD. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) DIAL | | 24B. DATE 12-29-66 | |
| 24C. NAME OF CEMETERY or CREMATORY Dulaney Valley | | 24D. LOCATION (City, town, or county) (State) BALTO Co MD | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1966 | | 25B. NAME OF REGISTRAR C.F. EVANS + SON | |
| 25C. FUNERAL DIRECTOR 8802 The End Rd | | ADDRESS | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

